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Introduction

The purpose of this document is to provide guidance and standards on the implementation of primary HIV prevention interventions in the District of Columbia. (The Centers for Disease Control and Prevention [CDC] defines primary prevention as "halting the transmission or acquisition of HIV infection" and secondary prevention as "halting or delaying the onset of illness in an HIV infected individual.")

An **intervention** is a specific activity (or set of related activities) intended to bring about HIV risk reduction in a particular target population using a common strategy for delivering the prevention messages. An intervention has distinct process and outcome objectives and a protocol outlining the steps for implementation. A **program** is an organized effort to design and implement one or more interventions to achieve a set of predetermined goals. [1]

Standards are provided in several sections. These standards should be applied consistently in the delivery of HIV prevention interventions. They must be followed in virtually all cases.

This document also provides overall **guidance** in developing and implementing HIV prevention interventions. The overall **guidance** is intended to be more flexible than the **standards**, and should be followed in most cases. The DC Department of Health HIV/AIDS Administration (HAA) recognizes that, depending on the client population, setting, and other factors, the overall guidance can and should be tailored to fit individual program needs.

HAA will evaluate the design of HIV prevention programs and interventions before they are implemented to ensure that they follow the guidance and standards for interventions. The information is listed in the order it appears in the following table, which was developed by the Centers for Disease Control and Prevention for its Evaluation Guidance.

The District of Columbia HIV Prevention Community Planning Group (HPCPG) uses information about behavioral science theory and evaluation to prioritize interventions. The interventions prioritized for target populations can be found in the District's comprehensive HIV Prevention Plan, which is updated every year.

Determining Justification of an Intervention for the Target Population and Setting

HAA staff is required to decide if the intervention plans of sub-grantees provide sufficient justification of the intervention for the target population and setting (i.e., justification). Sufficient justification is provided when sub-grantee's plan clearly explains how the intervention will lead to the specified outcomes in the specific population and in the sub-grantee's specific setting. Justification is different from evidence.

Evidence supports the rationale for the proposed intervention; justification provides greater detail about how and why the intervention will result in the stated outcomes with the specified target population and in the particular setting in which the intervention is conducted (e.g., clinic, bars, prison) [1]. Sub-grantees should provide descriptions of program theory that HAA can use to assess justification for the proposed intervention.

The Guidance Definitions

The CDC Evaluation Guidance establishes definitions for HIV prevention interventions. It distinguishes between interventions that do and do not include skills-building activities because the development of HIV risk-reduction skills is an important part of interventions that lead to behavior change.[1] By establishing definitions for use by all jurisdictions that receive CDC funding for HIV prevention activities, the Guidance facilitates uniform reporting of evaluation data to CDC and can improve the clarity of communications within a jurisdiction.

Intervention Definitions Used in CDC' s Evaluation Guidance [1]

Intervention	Definition	Excludes
Individual-Level Intervention (ILI) or Individual Prevention Counseling	Health education and risk-reduction counseling provided to one individual at a time. ILI assists clients in making plans for individual behavior change and ongoing appraisals of their own behavior and includes skills building activities. These interventions also facilitate linkages to services in both clinic and community settings (e.g., substance abuse treatment settings) in support of behaviors and practices that prevent transmission of HIV, and they help clients make plans to obtain these services.	Outreach and prevention case management. Each intervention constitutes its own category. Also excludes HIV counseling and testing which is reported in a separate category.
Group-Level Intervention (GLI) or Psycho-Educational Skills-Building Workshops	Health education and risk-reduction counseling that shifts the delivery of service from the individual to groups of varying sizes. GLI uses peer and non-peer models involving a wide range of skills, information, education, and support.	Any group education that lacks a skills component (e.g., information only education such as "one-shot" presentations). These types of interventions should be included in the HC/PI category.
Outreach	HIV/AIDS educational interventions generally conducted by peer or paraprofessional educators face-to-face with high-risk individuals in the neighborhoods or other areas where they typically congregate. Outreach usually includes distribution of condoms, bleach, sexual responsibility kits, and educational materials. Includes peer opinion leader models.	Condom drop offs, materials distribution, and other outreach activities that lack face-to-face contact with a client.
Prevention Case Management (PCM)	Client-centered HIV prevention activity with the fundamental goal of promoting the adoption of HIV risk-reduction behaviors by clients with multiple, complex problems and risk-reduction needs; a hybrid of HIV risk-reduction counseling and traditional case management that provides intensive, ongoing, and individualized prevention counseling, support, and service brokerage.	One-to-one counseling that lacks ongoing and individualized prevention counseling, support, and service brokerage.
Intervention	**Definition**	**Excludes**

Partner Counseling and Referral Services (PCRS)	A systematic approach to notifying sex and needle-sharing partners of HIV-infected persons of their possible exposure to HIV so they can avoid infection or, if already infected, can prevent transmission to others. PCRS helps partners gain earlier access to individualized counseling, HIV testing, medical evaluation, treatment, and other prevention services.	HIV counseling and testing, which is reported in a separate category using the standard bubble sheets.
Health Communication / Public Information (HC/PI)	The delivery of planned HIV/AIDS prevention messages through one or more channels to target audiences to build general support for safe behavior, support personal risk-reduction efforts, and/or inform persons at risk for infection how to obtain specific services. Electronic Media: Means by which information is electronically conveyed to large groups of people; includes radio, television, public service announcements, news broadcasts, infomercials, etc., which reach a large-scale (e.g., city-, region-, or statewide) audience. Print Media: These formats also reach a large-scale or nationwide audience and include any printed material, such as newspapers, magazines, pamphlets, and "environmental media" such as billboards and transportation signage. Hotline: Telephone service (local or toll-free) offering up-to-date information and referral to local services (e.g., counseling/testing and support groups). Clearinghouse: Interactive electronic outreach systems using telephones, mail, and the Internet/Worldwide Web to provide a responsive information service to the general public as well as high-risk populations Presentations/Lectures: These are information-only activities conducted in group settings; often called "one-shot" education interventions.	Group interventions with a skills-building component, which constitutes a separate intervention category.

Intervention	Definition	Excludes
Other	Category to be used for those interventions that cannot be described by the definitions provided for the other six types of interventions. This category includes community-level intervention (CLI). CLI are interventions that seek to improve the risk conditions and behaviors in a community through a focus on the community as a whole, rather than by intervening with individuals or small groups. This is often done by attempting to alter social norms, policies, or characteristics of the environment. Examples of CLI include community mobilizations, social marketing campaigns, community-wide events, policy interventions, and structural interventions.	Any intervention that can be described by one of the existing categories.

References:

1. Centers for Disease Control and Prevention; Evaluation Guidance Handbook: Strategies for Implementing the Evaluation Guidance for CDC-Funded HIV Prevention Programs; March 2002.

General Considerations Regarding HERR Activities

From "Guidelines for Health Education and Risk Reduction (HERR) Activities"

US Department of Health & Human Services
Public Health Service
Centers for Disease Control and Prevention
March 1995

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Introduction

Preventing the spread of human immunodeficiency virus (HIV) and sexually transmitted disease (STD) requires a comprehensive strategy composed of service delivery systems coupled with effective, sustained health education and health promotion interventions. These individual components of a prevention program must not operate in isolation, but must work together toward the well being of the person at risk and the community as a whole. All education activities related to HIV/STD prevention should contribute to and complement the overall goal of reducing high-risk behaviors.

The guidelines presented in this document are written to encourage HIV/STD prevention programs to focus on developing programs and services that are based on health education and health promotion strategies. In Health Behavior and Health Education: Theory, Research, and Practice, the authors describe the ultimate aims of health education as being "positive changes in behavior" (Glanz et al., 1990, p.9). Green and Kreuter further define health promotions as " . . . the combination of educational and environmental supports for actions and conditions of living conducive to health" (Green and Kreuter, 1991). Health education is a powerful tool in an epidemic in which the behavior of using a latex condom can make the difference in whether or not a person becomes infected with HIV.

It is critically important that members of the populations to be served are involved in identifying and prioritizing needs and in planning HIV/STD education interventions. Their involvement ensures that decisions are made, purposes are defined, intervention messages are designed and developed, and funds are allocated in an informed and realistic manner. Limited educational resources can be proactively directed to specific populations, rather than reactively directed or directed on the basis of guesswork or stereotyping.

Moreover, to be effective, an education intervention must be culturally competent. Participation of client populations throughout the process of designing and implementing programs helps assure that the program will be acceptable to the persons for whom it is intended. For the purposes of this document, cultural competence is defined as the capacity and skill to function effectively in environments that are culturally diverse and that are composed of distinct elements and qualities. Cultural competence begins with the HIV/STD professional understanding and respecting cultural differences and understanding that the clients' cultures affect their beliefs, perceptions, attitudes, and behaviors.

Health departments across the country have implemented an HIV prevention community planning process whereby the identification of a community's high priority prevention needs is shared between the health departments administering HIV prevention funds and representatives of the communities for whom the services are intended. The HIV prevention community planning process begins with an accurate epidemiologic profile of the present and future extent of HIV and acquired immunodeficiency syndrome (AIDS) in the jurisdiction. Special attention is paid to distinguishing the behavioral, demographic, and racial/ethnic characteristics of the epidemic. This is followed by an assessment of HIV prevention needs that is based on a variety of sources and is collected using different assessment strategies. Next, priorities are established among needed HIV prevention strategies and interventions for specific populations. From these priorities, a comprehensive HIV prevention plan is developed.

Of the eight essential components of a comprehensive HIV prevention program that are described in the community planning guidance document issued by CDC, four relate specifically to the interventions described in these Guidelines. These are as follows:

- Individual level interventions which provide ongoing health communications, health education, and risk reduction counseling to assist clients in making plans for individual behavior change and ongoing appraisals of their own behavior. These interventions also facilitate linkages to services in both clinic and community settings (e.g., substance abuse treatment settings) in support of behaviors and practices, which prevent transmission of HIV, and they help, clients make plans to obtain these services.
- Health communications, health education, and risk reduction interventions for groups, which provide peer education and support, as well as promote and reinforce safer behaviors and provide interpersonal skills training in negotiating and sustaining appropriate behavior change.
- Community level interventions for populations at risk for HIV infection, which seek to reduce risk behaviors by changing attitudes, norms, and practices through health communications, prevention marketing, (1) community mobilization/organization, and community-wide events.
- Public information programs for the general public, which seek to dispel myths about HIV transmission, support volunteerism for HIV prevention programs, reduce discrimination toward persons with HIV/AIDS, and promote support for strategies and interventions that contribute to HIV prevention in the community.

(More information on the HIV prevention community planning process is contained in the Handbook for HIV Prevention Community Planning (Academy for Educational Development, 1994) or from the HIV/AIDS Administration. All HIV health education and risk reduction activities should complement and support the priorities established in the HIV prevention comprehensive plan developed by the District of Columbia HIV Prevention Community Planning Group)

For the purpose of this document, communities are defined as social units that are at least one of the following: functional spatial units meeting basic needs for sustenance, units of patterned social interaction, or symbolic units of collective identity (Hunter, 1975). Communities are selected for interventions based on their specific and identified needs and on surveillance and seroprevalence data.

The recommendations in this document recognize that while communities may have different approaches to HIV/STD prevention programs, certain basic programmatic, management, and staff requirements are common to effective health education and risk reduction activities. These Guidelines describe the core elements that are essential for success in a number of types of health education and risk reduction activities – Individual and Group Interventions and Community-level Interventions – and in public information activities.

These guidelines are provided to assist program planners in enhancing their health education and risk reduction activities. In some cases, specific programs of state and local health departments have advanced beyond the basic steps outlined here. In other instances, programs may benefit greatly from these

suggestions. The priority activities described in this document can be used in a variety of settings and can also be applied to other health issues.

(1) Prevention marketing is CDC's adaptation of social marketing in which science-based marketing techniques and consumer-oriented health communication technologies are combined with local community involvement to plan and implement HIV/AIDS prevention programs. Essentially, prevention marketing = social marketing + community involvement.

Core Elements of Health Education and Risk Reduction Activities

A number of core elements should be considered in health education and risk reduction program and evaluation activities.

Effective Health Education and Risk Reduction program activities:

- State realistic, specific, measurable, and attainable program goals and objectives.
- Identify methods and activities to achieve specific goals and objectives.
- Define staff roles, duties, and responsibilities.
- Define the populations to be served by geographic locale, risk behavior(s), gender, sexual orientation, and race/ethnicity.
- Assure that educational materials and messages are relevant, culturally competent, and language- and age-appropriate.
- Include professional development for all program staff.
- Include a written policy and personnel procedures that address stress and burnout.
- Include written procedures for the referral and tracking of clients to appropriate services outside of the agency.
- Provide for collaboration with other local service providers to assure access to services for clients.
- Assure confidentiality of persons served.

Effective Health Education and Risk Reduction evaluation activities:

- Include process evaluation. (See Appendices.)
- Require consistent and accurate data collection procedures, including number of persons served, quantity and type of literature or materials distributed, and demographics of persons served. A description of the tools to be used and definitions of various measurements (e.g., "unit of service" and "contact") should be outlined.
- Include staff supervision, observation, evaluation, and feedback on a regular basis. (See Appendices B-D.)
- Include feedback from persons served.
- Designate staff that is responsible for evaluation and quality assurance activities, for compiling and analyzing data, and for documenting and reviewing findings.
- Define methods for assessing progress toward stated process goals/outcome objectives.
- Include mechanisms for measuring the use of referral services.
- Provide findings for program modifications.

Core Training for Health Education and Risk Reduction Activities

Staff training is an important element in the development of a sound program. The suggested areas in which health education and risk reduction staff should receive training are listed below. Not all staff members should receive training in all the listed areas. The outlined training areas provide various program and management staff with the specific technical support necessary to implement their component of the health education and risk reduction program.

Effective training plans for Health Education and Risk Reduction

- Provide basic HIV, STD, and tuberculosis (TB) health education information.
- Provide bleach use instruction.
- Increase knowledge of substance use/abuse.
- Provide orientation to human sexuality, including diverse lifestyles and sex practices.
- Enhance sensitivity to issues for persons living with HIV/AIDS and STDs.
- Recognize cultural diversity and enhance cultural competence.
- Provide an orientation to the agency, community, and available community resources.
- Include ongoing professional development for staff.
- Provide opportunities for role-play, observation, and feedback, including the use of video replay where possible.
- Provide training in the dynamics of community and agency collaboration.
- Enhance basic health education concepts.
- Provide orientation to community resources.
- Identify additional sources for updated information.
- Build communication skills (e.g., active and reflective listening, clear speaking).
- Provide for regular updates on analyses and programmatic interpretations of data.
- Provide training on program planning, operations, and supervision.
- Provide orientation to safer sex guidelines.
- Provide training on developing HIV/AIDS publications and resources.
- Enhance basic knowledge of family planning and contraception.
- Increase knowledge of treatment and therapy for people living with HIV and AIDS.
- Provide training on crisis intervention.
- Provide training on street and community outreach.
- Provide ongoing discussion on grief and bereavement.
- Provide training on confidentiality and privacy.

Community Needs Assessment

The HIV prevention community planning process requires an assessment of HIV prevention needs based on a variety of sources and different assessment strategies. This assessment serves as the basis for the development of a comprehensive HIV prevention plan. In addition, more targeted needs assessment may be needed for effective health education program planning for health departments and non-governmental organizations (NGOs). Tailored needs assessments enable the program planner to make informed decisions

about the adequacy, availability, and effectiveness of specific services that are available to the target audience.

For the purposes of developing specific health education and risk reduction activities, a targeted needs assessment assists in the following:

- Establishing appropriate goals, objectives, and activities.
- Defining purpose and scope.
- Identifying social/behavioral attitudes, behaviors, and perceptions of the target community.
- Providing the basis for evaluation as part of formative and summative studies of interventions.
- Establishing community-based support for the proposed activities.

The needs assessment may be informal or formal. An informal needs assessment may occur through frequent conversations and personal interactions with colleagues and clients. Staff and clientele interact with each other when services are being delivered; therefore, clients may inform them about services they find useful or unsatisfactory. Also, staff meetings are a vehicle for sharing and transferring information among colleagues. Through both of these processes, staff can usually determine whether there are gaps in services.

A formal needs assessment involves a systematic collection and analysis of data about the client population. This process may uncover needs that may not be identified through an informal process.

A formal needs assessment requires the program planner to do the following:

- Identify questions that need to be answered.
- Determine how the information will be collected and from whom.
- Identify existing sources of data, e.g., needs assessment data from the HIV prevention community-planning group.
- Collect the data.
- Conduct a comprehensive analysis of the data.

The program staff should review data from the HIV prevention community planning needs assessment to determine what additional information is needed. A variety of information would be useful in developing program activities, including the following:

- Socioeconomic and demographic status of the overall community and the specific populations being targeted.
- Current statistics and trends involving HIV/STD disease.
- Existing gaps in HIV/STD programs and services.
- Social indicator data to examine significant and relevant factors that influence prevalence of HIV/STD disease, e.g., substance abuse, teenage pregnancy.
- Identification of other programs and resources that focus on the same target audience.

Before conducting a needs assessment, program staff should consult with community leaders from the client or target populations. This is important in order to determine the leaders' perceptions of their communities' needs, to discuss the agency's plan for conducting the assessment, and to begin to cultivate a working relationship with the leaders in order to attain community support for the proposed activities.

How to Conduct a Needs Assessment

- Identify sources of information and data.
- Review existing literature on the specific problem.
- Survey other agencies/organizations in the community to avoid unnecessary overlap in program activities and to identify emerging issues and new resources.

- Interview key informants and community members who have knowledge of or experience with the problem.
- Consult with national/state agencies where specific data, literature, or experience is deficient.

How Needs Assessments Affect Program Evaluation

A needs assessment is a component of program evaluation. Each element of a needs assessment plays a significant role in the planning, implementation, and management of effective education programs. If a program is to be evaluated, the degree to which the program addresses the needs of the target audiences must be examined.

Both qualitative and quantitative methods of data collection and evaluation are useful. Qualitative methods afford the target audiences an opportunity to express their thoughts, feelings, ideals, and beliefs. Examples of qualitative methods include informal interviews, focus groups, and public forums. These methods are designed to assist the program staff in identifying problems or gaps that the agency may not have recognized, e.g., barriers to service delivery and client dissatisfaction.

Quantitative methods render statistical information. Examples include questionnaires and surveys, results of studies of the client populations' attitudes and beliefs about HIV/STD disease, and information derived from program activities, e.g., number of condoms distributed and documented requests for services.

Note: For further reading on needs assessment, see "Chapter 5: Assessing and Setting Priorities for Community Needs," Handbook for HIV Prevention Community Planning, Academy for Education Development, April 1994.

Collaborations and Partnerships

The HIV prevention community planning process calls for health departments and affected communities to collaboratively identify the HIV prevention priorities in their jurisdictions. However, some members of these affected communities distrust health departments. They may feel that government officials have not traditionally reached out to them until certain health issues have also threatened the greater public health, i.e., the majority community. Sexually transmitted diseases, other communicable diseases, and substance abuse have long been problems in disadvantaged and disenfranchised communities. Injecting drug users (IDUs) were dying of endocarditis, hepatitis B, and drug overdose long before AIDS. For years, the tuberculosis epidemic persisted in poor African American and Hispanic neighborhoods, while prevention and treatment resources dwindled. Consequently, developing collaborative working relationships with affected communities for the purpose of HIV prevention may pose special challenges to many state and local health departments.

In the United States, public health officials frequently underestimate the strengths and resourcefulness of affected communities. As a result, state and local health departments and communities have seldom come together in partnership. In many instances, state and local health departments have not sought the support of, or consulted with, community members before designing and implementing community intervention efforts. At times, public health officials may have inadvertently stigmatized communities in their attempts to intervene and promote public health.

Affected communities are acutely aware of the peculiarities of public health as it relates to them. Some have asked, "Is this a war on drugs or on us" Despite government support for community-base and HIV prevention community planning, many communities remain wary of public health programs as they have been implemented by officials in their communities.

As if this lack of confidence were not challenging enough to state and local health departments, many communities genuinely suspect conspiracy when health officials implement programs for them. Many disadvantaged, disenfranchised persons not only distrust the government, but they may also fear it. For African Americans, the Tuskegee Study continues to cast its own specter of doubt as to whether or not

public health officials are truly committed to ensuring the public's health. Hispanic farm workers continue to struggle with government pesticide regulators who seem indifferent to the dangers that farm workers face in the workplace. For Native Americans living on reservations, the quality of health is chronically poor, and life expectancy is diminished. Within many communities, there is a pervasive belief that the government "does not care," or worse, that it "will experiment on them."

Although the AIDS epidemic has illustrated the real value of developing partnerships among local and state health departments and communities, achieving communication, collaboration, and cooperation with these communities and maintaining the relationships in a climate of distrust, apathy, and even fear is daunting. Such a task will surely require cultural sensitivity, competency, respect, and the most critical of all elements, time.

In particular, for an effective HIV prevention community planning process, state and local health departments must develop strong linkages and collaborations with affected communities. A working definition of collaboration is the process by which groups come together, establishing a formal commitment to work together to achieve common goals and objectives. Collaborative relationships are also referred to as coalitions or partnerships. Regardless of the term, the concept is a crucial one.

To facilitate the formation of effective community planning groups and other partnerships, health departments need to understand not only the knowledge and behaviors of their client populations, but also their attitudes toward and beliefs about their own communities, the government, and public health. Health departments will want to assess these same issues among their own employees. In addition to this understanding, to fully achieve cultural competence, to have the capacity and skills to effectively function in environments that are culturally diverse and composed of distinct elements and qualities, health department professionals must also develop a respect for cultural differences. They must appreciate how culture and history affect their clients' perceptions, beliefs, attitudes, and behaviors, as well as their own.

For many health departments and community organizations, responding to the AIDS epidemic means long-term institutional change. Simply channeling HIV resources to affected communities through community-based and national non-go formation of real working relationships among partners who perceive each other as equal. The community planning process addresses these issues by emphasizing the importance of assuring representation, inclusion, and parity in the planning process.

An important program objective for health departments may be to gain acceptance and credibility in the communities they seek to serve. To assume that these will come automatically or even easily may demonstrate cultural insensitivity and incompetence. Respect and regard for the perceptions of those being served will help eliminate barriers to HIV prevention and will build the bridges to better health.

How Can Collaborations Help?

Collaborations can:

- Facilitate strategic planning.
- Help prevent duplication of cost and effort.
- Maximize scarce resources.
- Integrate diverse perspectives to create a better appreciation and understanding of the community.
- Provide comprehensive services based on the client's needs.
- Increase client accessibility to health services.
- Improve communication between the health department and its constituents.
- Provide liaison for clients unwilling to seek services from government organizations.

At the same time, public health agencies must be aware of some of the difficulties inherent in collaborative relationships:

- Organizations and individuals may have hidden agendas.
- Intra-agency trust may be difficult to develop.
- Decision-making processes may become complicated.
- Organizations have to collectively take the responsibility for program objectives, methods, and outcomes.
- The group may lack a clear sense of leadership and direction.
- The group may lack a clear sense of its tasks and responsibilities.

What Influences the Success of a Collaborative Effort?

Many factors influence the success of a collaborative effort; however, the following factors are vital:

- The group must develop a sense of mutual respect, trust, purpose, and understanding.
- There must be an appropriate representation of groups from all segments of the community for whom the activities will have an impact.
- All members must "buy into" and develop ownership in the development and outcome of the process.
- Effective communication among members must be constant and ongoing.
- The group must position itself as a leader in the community, eager to work with persons from all communities in developing effective prevention strategies.
- The group must be willing to try non-traditional strategies.

The development and maintenance of collaborative relationships are challenging and rewarding tasks. Collaborations can make positive, significant changes in communities, if they are developed in a way that is culturally competent and respectful of the people for whom interventions will be developed. Health departments must also consider whether efforts are cost-efficient, appropriate, duplicative, and accessible; they must determine where community-based organizations fit into the overall realm of prevention activities. Collaborations should be structured with long-term results in mind. They should serve as a bridge to better relations between state and local health departments and the community, ultimately effecting better health in the community.

Individual-Level Interventions (ILI)

Individual-level interventions (ILI) consist of health education and risk-reduction counseling provided to one individual at a time. ILIs assist clients in making plans for individual behavior change and ongoing appraisals of their own behavior. These interventions also facilitate linkages to services in both clinic and community settings (e.g., substance abuse treatment settings) in support of behaviors and practices that prevent transmission of HIV, and they help clients make plans to obtain these services. An example of ILI is individual prevention counseling.

Individual Prevention Counseling

The purpose of individual prevention counseling is to provide one-time counseling and health education interventions to persons who are at high risk for HIV infection, to promote and reinforce safe behavior. This type of counseling -- which is not linked with HIV antibody testing -- provides education and counseling at sites where individuals at risk for HIV congregate for purposes other than receiving HIV prevention or education, such as drug treatment centers, social service offices, or medical clinics. Individual prevention counseling may be delivered by peers or non-peers.

Guidance and Standards for Individual Prevention Counseling

INTRODUCTION

The purpose of Individual Prevention Counseling (IPC) is to provide personalized counseling and health education interventions to persons who are at high risk for HIV infection, to promote and reinforce safe behavior. This type of counseling is not linked with HIV antibody testing, although it is similar to pre-test counseling.

It can be a one-time intervention, or the client and counselor can meet multiple times. The intervention creates the opportunity for an individual to learn to recognize her/his own risk, ask questions about safer sex in a safe environment, and formulate personal risk reduction plans.

IPC also involves building skills to change the behaviors that put one at risk for HIV and providing support for maintaining a low risk status. Counselors assist clients in making plans for individual behavior change and ongoing appraisals of their own behavior. Counselors also provide referrals and information in support of behaviors and practices that prevent transmission of HIV, and they help clients make plans to obtain these services.

Individual Prevention Counseling provides education and counseling at sites where individuals at risk for HIV congregate for purposes other than receiving HIV prevention or education, such as drug treatment centers, community-based organizations, or medical clinics. But is also provided to participants in other prevention interventions who demonstrate the need for individualized intervention but do require a more intense intervention like prevention case management. IPC is also a highly mobile intervention that can take place in an outreach activity.

These interventions also facilitate linkages to services in both clinic and community settings

This guidance is based on the CDC guidance for Counseling and Testing and on the CDC guidance for Prevention Case Management. The two levels of recommendations this document provides are as follows:

Standards: Specific standards are provided in several sections. These standards should be applied consistently to the delivery of individual prevention counseling services. They must be followed in virtually all cases.

Guidance: The main text of this document provides overall program guidance in developing, implementing, and evaluating Individual Prevention Counseling programs. The overall guidance is intended to be more flexible and should be followed in most cases. The overall guidance can and should be tailored to fit individual program needs.

Goals of Individual Prevention Counseling (IPC)

The goals of an IPC program are as follows:

- To provide individualized HIV risk-reduction counseling to help initiate and maintain behavior change to prevent the transmission or acquisition of HIV;
- To facilitate referral services, as needed, for clients' medical and psychosocial needs that affect their health and ability to change HIV-related risk-taking behavior; and
- To provide information and referrals, as needed, for HIV secondary prevention needs of persons living with HIV or acquired immunodeficiency syndrome (AIDS).

Necessary Elements of IPC

- **Prevention Counseling:** Counseling provides a critical opportunity to assist the client in identifying his or her risk of acquiring or transmitting HIV. It also provides an opportunity to negotiate and reinforce a plan to reduce or eliminate behavioral risk.
- **Provision of Referrals:** Clients may require referral for physical and psychological evaluations, appropriate therapies (i.e., drug treatment), and support services to enhance or sustain risk reduction behaviors. Each program should maintain complete knowledge of referral resources, including the availability, accessibility, and eligibility criteria for services.

Standards for Service Provision

Required

- According to the Units of Service document developed by the SFDPH HIV Prevention Section, counseling sessions must be at least 30 minutes long and must include:
  1) HIV/STD information and dissemination;
  2) Documentation of discussion of risk behaviors;
  3) Counseling;
  4) Skills building;
  5) Documented referral(s), if given; and
  6) Documentation of client demographics.
- Counseling must be client-centered and focus on the needs of the individual.
- Counseling should acknowledge substance use, housing issues, joblessness, etc. as possible barriers to HIV prevention; and should provide linkages to services for housing, substance treatment, jobs, etc.
- Counselors should be able to demonstrate that they understand how the target population is affected by other (non-HIV-specific) issues, and should address those issues to some degree, whether by referrals or otherwise.
- Staff in clinic or other health care settings is given adequate training in client-centered counseling.
- Staff/volunteers should be trained in issues relevant to adolescents.

Recommended

- Peer models can be very effective in delivery of IPC.

Guidelines for Providers

Risk Assessment Development

Agencies should provide prevention counseling tailored to individual client needs and should develop an effective method to involve clients in identifying their risk behaviors. This approach should also address local and specific circumstances that might influence the client's perception of risk.

Standards

HIV prevention program managers must make certain that the following are achieved:

- Provision of training and quality assurance to ensure that staff has the adequate skills to (1) identify and assess risk behavior of all clients counseled, and (2) to make appropriate referrals when necessary;
- Determination of appropriate site-specific strategies, approaches and tools for risk assessment of clients, based on demographic and risk profiles;
- Procedures to maximize targeting of clients for prevention counseling based on risk profiles.

Referral Service Development

A thorough client assessment often indicates a need for services that cannot be provided by the counselor (e.g. drug treatment, peer support groups, etc.). To ensure that clients receive appropriate care, the program must establish a procedure for referring persons to sites that provide services in a timely, efficient, and professional manner. A collaborative relationship should have already been established with the appropriate representative of the referral site. Program managers should routinely conduct site visits to referral sites, as a quality assurance measure to ensure that settings and services are appropriate to client needs.

Program managers should maintain a current list of community and institutional referral resources such as HIV prevention programs, mental health services, infectious disease specialists and clinics, free clinics, social service agencies, emergency medical services, hospitals, prenatal care clinics, family planning clinics, AIDS service organizations, HIV/AIDS community-based organizations (CBOs), substance abuse treatment facilities, and religious institutions.

Counseling should acknowledge substance use, housing issues, joblessness, etc., as possible barriers to HIV prevention; and should provide linkages to services for housing, substance treatment, jobs, etc.

Special Considerations

Some clients may be in need of prevention case management services (PCM), a highly individualized and intensive HIV risk-reduction strategy. PCM is intended for persons at greatest risk of transmitting or acquiring HIV whose needs are not being effectively served and whose behavior is not influenced by less intensive HIV prevention interventions, such as street outreach, group-level strategies, or individual prevention counseling.

Characteristics of PCM differentiate it from other prevention activities. PCM characteristics include the following:

- The formal enrollment of "clients" into an on-going service guided by professional standards.
- The development of a formal relationship between a prevention case manager and a client, a relationship that is characterized by active, cooperative prevention planning, problem solving, counseling, and referral provision.
- In-depth, on-going, risk-reduction counseling that addresses specified behavioral objectives.
- The need for professional staff skills to conduct most functions of PCM, including assessment, prevention planning, and risk-reduction counseling.

Some clients may require more than one session of IPC, which is not as intensive or comprehensive as PCM. Program managers should develop agency protocols for the provision of referrals to other IPC sessions (i.e. multi-sessions of IPC), given the risk profiles of the target populations served.

Standards

HIV prevention program managers must develop a process for routine referral that includes the following:

- A written referral process for identifying, evaluating, and updating referral sources in the site's operations manual;
- A mechanism to provide clients with immediate access to emergency psychological or medical service;
- Appropriate referral resources for;
    1. Any client at-risk for HIV infection who may be in need of support to maintain safer behaviors,
    2. Clients who continue to engage in risk behavior,
    3. HIV positive persons who need a medical assessment.

Client Recruitment

Individuals in need of individual prevention counseling are often identified during group-level interventions, such as psycho-educational skills building groups. Facilitators of these activities should offer their services for this intervention, which could be provided at the end of the group session or at another time agreed to with the client.

Making an IPC program well known and visible for those persons the program intends to serve is important. Recruitment strategies might include:

(1) Training outreach workers and group facilitators to identify individuals in need of counseling and make referrals to the service;
(2) Recruiting clients from other programs such as an STD clinic, a women's health clinic, or a drug treatment program.
(3) Training outreach workers and group facilitators to identify individuals in need of counseling and make referrals to the service;
(4) Developing materials advertising this service and making them available at all prevention activities.
(5) Recruiting clients from other programs such as STD clinics, health clinics or a drug treatment programs.

Educational and Risk Reduction Materials

Culturally competent, linguistically specific, and developmentally appropriate written HIV information must be available to clients. Current written materials should be prominently displayed in public areas and made available to clients.

In addition, condoms and other risk reduction materials should be available to the client—directly from providers and easily accessible without the client having to ask.

Guidelines for Counselors

Risk Assessment

Risk assessment – an integral component of HIV prevention counseling – is based on the premise that certain behaviors increase risk for infection with HIV. The counselor should engage the client in a discussion that enables the client to recognize risk for HIV. Because the risk-assessment process serves as the basis for assisting the client in formulating a plan to reduce risk, it is an essential component of all counseling. The approach should be client-centered, with the counselor assisting the client in recognizing and understanding their HIV-risk.

When the counselor assesses a client's risk, the approach should be thorough and individualized for each client. The counselor should accept that the client's disclosures concerning risk behaviors correspond to his or her readiness to initiate behavior change. Each counselor should develop effective interactive methods to involve the client in identifying risk behaviors and initiating risk reduction measures. Counselors should understand how the target population is affected by other (non-HIV-specific) issues, and should address those issues to some degree, whether by referrals or otherwise.

Standards

Determine the client's prevention and clinical needs by engaging him/her in a discussion that addresses: client's reason for participating in the session and other relevant concerns; client's resources and support systems; behavioral and other sources of risk, demographic and epidemiologic factors that influence risk; client awareness of risk; readiness to change behavior; and receptiveness to available services and referrals.

Listen for and address, as appropriate, information such as the following:

- Number of sex partners (casual and steady) and sexual activities including vaginal, anal, and oral sex, both receptive and insertive activities;
- Sex in exchange for drugs, money, or other inducements;
- Use of substances such as alcohol, cocaine, etc., in connection with sexual activity; and
- Condom use and other "safer-sex" methods utilized by the client.

Individual Prevention Counseling

Counseling provides a critical opportunity to assist the client in identifying his or her risk of acquiring or transmitting HIV. Counseling also provides an opportunity to negotiate and reinforce a plan to reduce or eliminate the risk. Prevention counseling should also:

1) Facilitate an accurate perception of HIV risk for those who are unaware, uninformed, misinformed, or in denial;
2) Translate the client's risk perception into a risk reduction plan that may be enhanced by knowledge of HIV infection status; and
3) Help clients initiate and sustain behavior changes that reduce their risk of acquiring or transmitting HIV.

Standards

Provide client-centered counseling to:

- Establish and/or improve the client's understanding of his/her HIV risk;
- Assess the client's readiness to adopt safer behaviors by identifying behavior changes the client has already implemented; and
- Involve the client in an assessment to determine which of his or her behaviors may result in a risk of acquiring HIV infection.
- Tailor the counseling session to the behaviors, circumstances, and special needs of the client.
- Assist the client in recognizing those behaviors that put him or her at risk for HIV.
- Identify steps already taken by the client to reduce risk and provide positive reinforcement.
- Identify barriers/obstacles to the client's previous efforts to reduce risk.
- Determine one or two behavioral changes the client may be willing to make to reduce risk.
- Discuss the steps necessary to implement these changes.
- Address any difficulties the client anticipates in taking these steps.
- Respond to the client's concerns.

SPECIAL CONSIDERATIONS

As part of the assessment, the counselor should ascertain the client's understanding of HIV transmission. When appropriate and relevant to the client, the counselor may review risk reduction options with the client, for example:

- Abstain from sex and injecting street drugs; enroll in a drug treatment program.
- Practice mutual monogamy between two HIV negative persons.
- Use condoms and other barriers to prevent STDs and HIV transmission.
- Modify sexual practices to low or no risk behaviors.
- Limit the number of sex partners.
- Disinfect drug-injecting equipment and avoid sharing paraphernalia.
- Discuss related healthy behaviors, such as limiting the use of alcohol and other drugs.

CDC Guidelines for Risk Reduction Counseling

From the CDC "Guidelines for Health Education and Risk Reduction (HERR) Activities, March 1995

The purpose of risk reduction counseling is to provide counseling and health education interventions to persons who are at high risk for HIV infection. The interventions promote and reinforce safe behavior. The participants may range from a single individual to couples, families, groups, or entire communities.

Risk reduction counseling is interactive. Such counseling assists clients in building the skills and abilities to implement behavior change. These programs offer training in the interpersonal skills needed to negotiate and sustain appropriate behavior changes. For example, sessions could concentrate on delaying the initiation of sexual activity, on methods for avoiding unsafe sex and negotiating safer sex, and on techniques to avoid sharing injecting drug paraphernalia. Risk reduction may be implemented in a variety of formats. The interventions may take the form of role-plays, safer sex games, small group discussion, individual counseling, or group counseling.

Effective risk reduction counseling sessions:

- Emphasize confidentiality.
- Begin with an assessment of the specific HIV/STD prevention needs of the client(s).
- Identify, with the group or individual, the appropriate goals/ objectives (e.g., condom use negotiation skills for female sex partners of IDUs).
- Use skills-building exercises designed to meet the specific needs of the client(s).
- Include negotiations with the client(s) on suggestions and recommendations for changing and sustaining behavior change as appropriate to their situation.
- Enable/motivate participants to initiate/maintain behavior change independently.
- Enhance abilities of the participant(s) to access appropriate services (e.g., referrals to drug treatment).

Risk Reduction Program Plans

An effective risk reduction program plan includes the following:

- Protocols and procedures specific to each activity and logistical check lists for implementation.
- Development of innovative behavior modification strategies.
- Provision for regular updates in techniques for skills building.
- Provisions for updates on client-focused approaches to risk reduction activities.
- Provision for updates in techniques for increasing facilitators' skills in managing group or one-on-one dynamics.

Group-Level Interventions (GLI)

Group-level Interventions (GLIs) consist of health education and risk-reduction counseling that shift the delivery of service from the individual to groups of varying sizes. GLIs use peer and non-peer models involving a wide-range of skills, information, education, and support.

Some providers may consider general education activities to be group-level interventions. However, for the purposes of CDC reporting, GLI does *not* include "one-shot" educational presentations or lectures that lack a skills component.

Interventions that focus on groups as a target for HIV prevention and education may be structured to encourage the initiation and maintenance of safer behaviors, to provide interpersonal skills training, and/or to sustain appropriate behavior change. As with individual counseling, the intervention may be delivered by a peer or a non-peer. Programs usually include information about condom use, negotiation of safer sexual behaviors and risk-reduction strategies for IDUs. Unlike CTRPN and individual interventions, group interventions may target those at low risk for HIV/AIDS as well as those at high risk. An example of group-level interventions is psycho-educational skills-building groups.

Standards for Psycho-Educational Skills-Building Groups

Psycho-Educational Skills-Building Groups are based on the Health Belief Model – which identifies the key elements of decision making, such as the person's perception of susceptibility, perceived severity of the illness, and the perceived barriers to prevention – and on Social Cognitive Theory – which views learning as a social process influenced by interactions with other people.

Individuals participate in multiple-session group workshops. They attend anywhere from 4 to 12 sessions – for a total of 12 to 24 hours – that are designed to increase their ability to initiate and sustain safer-sex, risk-reduction and healthy behaviors. Workshop topics usually build on each other from session to session. Multiple sessions provide an opportunity to go into greater depth about HIV risk reduction issues and strategies, providing an enhanced opportunity for behavior change.

Psycho-educational skills-building programs include the following essential components:

- Interventions are conducted at locations and times that are convenient and safe for the target population.
- Sessions are facilitated by a trained facilitator or professional in a manner that is culturally and linguistically appropriate for the target population.
- Workshops provide the opportunity for confidential, one-on-one interactions with the provider before or after the intervention (individual level counseling).
- The format includes hands-on activities, such as role-playing.
- The sessions incorporate practical, useful skills-building exercises or demonstrations based on the needs of the target population.
- Topics or issues covered in the workshops sessions include information and education on risk and harm reduction; self-risk; self-esteem; self-efficacy; communication and negotiation skills; problem and conflict resolution; substance abuse; peer pressure; cultural norms such as religious beliefs and family values; and gender identity and sexual orientation.
- The interventions address psycho-cultural issues that are not necessarily related to HIV but may prevent members of the target population from engaging in safer sex and other healthy behavior

consistently. This includes co-factors such as a history of sexual, physical and mental abuse; poverty, homelessness, unemployment, lack of social support, mental health stressors and lack of access to prevention resources due to lack of knowledge of services, language or literacy.

- The program continually identifies additional issues and community needs to be addressed.
- Facilitators and other staff provide referrals to other prevention services, including counseling and testing, individual counseling, prevention case management, substance abuse treatment and mental health services.

Other Considerations

Multiple session group workshops should provide incentives for participants that are appropriate to the workshops and the target population, especially for hard-to-reach groups. Providers can encounter difficulty in trying to recruit or retain participants for continuing groups and may require a "hook" other than HIV prevention to motivate regular attendance, particularly for youth participants.

The effectiveness of time-limited psycho-educational skills-building groups can be enhanced if participants are linked to follow-up support groups (peer and non-peer-led) to help participants maintain healthy behavior.

Counselors should follow-up with participants to evaluate the adoption or maintenance of safer behaviors.

Using Support Groups for HIV Prevention

From the CDC "Guidelines for Health Education and Risk Reduction (HERR) Activities, March 1995

Groups can provide significant informational and therapeutic HIV risk reduction interventions to individuals who are ready to initiate and/or maintain specific health promoting behaviors. Groups are usually formed around common issues or problems. Some groups, originally established to provide information and skills training, may evolve into support groups, which encourage maintenance of newly acquired behaviors. Utilizing groups suggests a systems approach to intervention. Groups provide access to social networks that enable and reinforce health enhancing behavior change through peer modeling and peer support.

Although open-ended groups (e.g., support groups) may have less structure than the more close-ended kinds of groups (e.g., educational or skills-building), both types should have clearly defined goals/objectives and specifically defined processes. The structure of a group should be determined based upon the needs of the members.

At times, the open-ended group with its open enrollment and extended life is more suited to members' needs. By being open-ended, potential members are able to drop in when they need to and thus avoid the wait for new groups to form. This type of group is likely to appeal to the individual whose commitment to the group's process is initially limited. In the open-ended group, members determine their own topic of discussion at each meeting. For this reason, an open-ended model, that encourages drop-ins, is perhaps less amenable to instructional sessions that usually need to build on information presented at earlier meetings. The open model, because of its unpredictable structure and enrollment, may be more amenable to process evaluation (i.e., percentage of agency's clients attending a determined number of sessions).

The close-ended model will have a defined lifespan and is also likely to set membership limits. The closed group allows for important continuity and facilitating the development of trust among members, as they get to know each other over time. Members can expect the same individuals to be present each week, which can aid in building significant, supportive relationships. The closed group model is more suitable to the establishment of client-specific outcome objectives that can be monitored over time (i.e., self-reported reduction in number of sex partners at the end of 8 weeks of group attendance).

There are significant advantages to both open and closed models, and determination of which model to employ is based on the needs of an agency's clients and on an agency's capacity to implement the model. Whatever the model selected, the size of the group is an important consideration. Group facilitation is not crowd control. Smaller groups can be more manageable and result in enhanced group dynamics.

Group facilitators or instructors may be peers or professionals; in some instances, they may be both. They should be skilled at promoting effective group dynamics, encouraging reticent members to speak up and guiding the dominant ones. Skilled facilitators and instructors are astute observers. They not only listen to what is being said, but they also note nonverbal cues. Good observation skills are especially critical for support or therapeutic group facilitators. Skilled facilitators and instructors are able to see changes in body language, hear sighs, and catch subtle changes in facial expressions.

Groups are a naturally occurring phenomenon. People come together for a variety of reasons and left to themselves, they will develop informal but powerful supportive networks. Proactive HIV risk reduction programs can tap into this resource and enhance program effectiveness.

Outreach

Outreach is a face-to-face interaction between an outreach worker (or a team of outreach workers) and a client or a small group of clients that takes place in venues where the target population may congregate at appropriate times of the day, night, week, and year. Street outreach programs aim to encounter clients in their own community who are unlikely to be receiving important HIV prevention services. Outreach may be a one-time intervention or part of a long-term relationship established by the outreach worker with clients in a particular venue.

Outreach interventions are generally conducted by peer or paraprofessional educators, and usually include distribution of condoms, barriers, bleach and educational materials. Outreach workers also provide referrals to prevention, substance abuse, mental health and other programs that may help individuals adopt or maintain safer behavior.

Outreach has been shown to be effective in changing various risk behaviors among different populations. It has been successful for decreasing injection drug use-related risk behavior[1] as well as sexual risk behavior[2]. In addition, having had contact with an outreach worker has been associated with other preventive behaviors, such as getting an HIV test and carrying condoms among homeless youth[3].

However, not all populations have shown equal levels of behavior change (e.g., women and youth showed the least sexual behavior changed in the Birkel study[2].

References:

1 Watters JK, Downing M, Case P, et al. (1990) AIDS prevention for intravenous drug users in the community: Street-based education and risk behavior. AmJ Commun Psychol 18(4):587-596. Weibel W, Jiménez A, Johnson W, et al. (1993) Positive effect on HIV seroconversion of street outreach interventions with IDUs in Chicago (abstract). Presented at the IXth International Conference on AIDS; 1993; Berlin, Germany.

2. Birkel RC, Golaszewki T, Koman III JJ, et al. (1993) Findings from the Horizones Acquired Immune Deficiency Education Project: The impact of indigenous outreach workers as change agents for injection drug users. Health Educ Q 20(4):523-538.

3. Clements K, Gleghorn A, Garcia D, et al. (1997) A risk profile of street youth in northern California: Implications for gender-specific human immunodeficiency virus prevention. J Adolesc Health 20(5):343-353.

Condom Distribution

Condom use is an extremely effective harm reduction intervention for decreasing risk for HIV infection[1], and condom distribution ensures availability and accessibility of condoms. Condom distribution has also been associated with increased condom use African American men and women in one community-level, targeted distribution effort[2]. The cost savings to the health care system and society per condom used consistently and correctly is $27 for high-risk heterosexuals and at least $530 per condom for MSM[1], making this a highly cost-effective strategy.

The distribution of free condoms may reduce barriers to safer sex for some populations (e.g., for those who cannot afford condoms, those who are embarrassed to buy condoms such as teens). But condom distribution may have limited effectiveness in some populations unless accompanied by other interventions or strategies.[3]

Condom distribution methods should:

- Be used in combination with other strategies or interventions (i.e., it is not an intervention in itself).
- Be accompanied by instructions for proper use, either verbal or written.

- Be accompanied by information about the benefits and risks of nonoxynol-9, if condoms with nonoxynol-9 are distributed. (The CDC no longer recommends Nonoxynol-9 as an effective means for preventing HIV transmission.)
- Be applied to the distribution of microbicides, if and when they become available for use with vaginal or anal sex.

References:

1. CDC; Condoms and their use in preventing HIV infection and other STDs. September 1999.

2. Cohen DA, Farley TA, Bedimo-Etame JR, et al.; Implementation of condom social marketing in Louisiana. Am J Public Health 89(2):204-208, 1999

3. 2001 San Francisco HIV Prevention Plan

Standards for Outreach Interventions

Outreach programs should be consistent and continuous and involve client follow-up when possible. Outreach programs include the following essential components:

- Face-to-face outreach interventions in community settings at appropriate times of the day/night, week and year;
- An assessment of a client's needs and a dialogue about a client's issues regarding HIV, including any continued risk behaviors in the face of HIV knowledge
- Education on HIV transmission and on substance abuse/harm reduction that is provided in face-to-face interactions and promote the client's current prevention needs, whether these are for no interaction, prevention materials only, basic information, referrals to or on-the-spot case management, or counseling on HIV test results;
- Distribution and demonstration of prevention materials, such as male and female condoms and bleach kits, and culturally and linguistically appropriate written information on the correct use of condoms and bleaching kits;
- Distribution of culturally and linguistically appropriate literature on HIV prevention, substance abuse, and harm reduction;
- Referrals to prevention and substance abuse programs, as well as to services that can provide support in maintaining a client's seronegative status, such as mental health services, housing and shelter services, and support groups for HIV-negative individuals
- Establishing the educators and the agency they represent as resources for the community regarding HIV, STDs, substance abuse and support for other issues (such as homophobia and discrimination based on gender identity).

CDC Guidelines on Outreach

From the CDC "Guidelines for Health Education and Risk Reduction (HERR) Activities, March 1995

Street outreach commonly involves outreach specialists moving throughout a particular neighborhood or community to deliver risk reduction information and materials. The outreach specialist may set up an HIV/AIDS information table on a street corner. They may supply bleach to injecting drug users at shooting

galleries and condoms to commercial sex workers and their customers at the hotels or locations that they frequent. The fundamental principle of street outreach is that the outreach specialist establishes face-to-face contact with the client to provide HIV/AIDS risk reduction information and services.

Effective street outreach staff:

- Know the target group's language.
- Have basic training and experience in health education.
- Are sensitive to community norms, values, cultural beliefs, and traditions.
- Have a shared identity with the population served, stemming from shared common personal experiences with the group.
- Are trusted by the group they serve.
- Act as role models to the clients they serve.
- Advocate for the population served.
- Act as liaisons between the community and the agency.
- Are informed about community resources and use them.

Street outreach is not simply moving standard agency operations out onto the sidewalk. A number of specific issues are unique to the delivery of services through this type of outreach and must be considered before instituting a program of street outreach. These matters are usually addressed in an agency's street outreach program plan and include the following:

- Regular contact among educators, outreach specialists, and supervisors.
- Observation of potential outreach areas to determine the locations, times of day, and the days of the week that are most productive for reaching the population to be served.
- A written and comprehensive field safety protocol that is regularly updated.
- Establishment of and adherence to regular and consistent schedules of activities, including times and locations.
- A mechanism for measuring the use of referral services.
- Creation and maintenance of a positive relationship between the agency and the local law enforcement authorities.
- Identification and development of collaborative relationships with gatekeepers (key informants) in the community.
- Activities for building and earning the trust and respect of the community.
- Descriptions of skills-building exercises relevant to stated program objectives.
- Establishment of mechanisms for maintaining client confidentiality.

References:

1. Centers for Disease Control and Prevention; Condoms and their use in preventing HIV infection and other STDs. September 1999

2. Cohen DA, Farley TA, Bedimo-Etame JR, et al. Implementation of condom social marketing in Louisiana. Am J Public Health 89(2):204-208; 1999

3. 2001 San Francisco HIV Prevention Plan

Using Peers in HIV Prevention Interventions

While any intervention can be delivered either by a non-peer professional or by a trained peer, available data suggest that peer-based interventions are superior for achieving behavior change.

Peer education should not be seen as an intervention in itself but as a major component of individual, group and community level interventions, such as street outreach. It involves providing prevention services by individuals who are recruited from the target population and trained in HIV, substance abuse, peer counseling and outreach.

Peer education is based on the diffusion of innovation theory, which suggests that people are more likely to adopt new behaviors if they receive information from someone that is similar to them and is perceived as a role model. Programs using peer education should include the following elements:

1. Training, counseling and supervision of peer educators.
2. Safety protocols and support structures for the educators.
3. An agreement detailing the responsibilities of peer educators.
4. Peer education programs should also provide:
    - Incentives or compensation for the peer educators.
    - A mechanism to incorporate feedback and the experiences of the peers into program development.
    - A mechanism to insure diversity among the peer educators.

CDC Guidelines for Programs Using Peer Educators

From the CDC "Guidelines for Health Education and Risk Reduction (HERR) Activities, March 1995

Agencies that provide street and community outreach will frequently engage peer educators to conduct intervention activities. Peer education implies a role-model method of education in which trained, self-identified members of the client population provide HIV/AIDS education to their behavioral peers. This method provides an opportunity for individuals to perceive themselves as empowered by helping persons in their communities and social networks, thus supporting their own health enhancing practices. At the same time, the use of peer educators sustains intervention efforts in the community long after the professional service providers are gone.

Effective peer educators:

- Have a shared identity with the targeted community or group.
- Are within the same age range as the targeted community or group.
- Speak the same "language" as the community or group.
- Are familiar with the group's cultural nuances and are able to convey these norms and values to the agency.
- Act as an advocate, serving as a liaison between the agency and the targeted community or group.

Peer education can be very powerful, if it is applied appropriately. The peer educator not only teaches a desired risk reduction practice but s/he also models it. Peer educators demonstrate behaviors that can influence the community norms in order to promote HIV/AIDS risk reduction within their networks. They are better able to inspire and encourage their peers to adopt health-seeking behaviors because they are able to share common weaknesses, strengths, and experiences.

Agencies often recruit and train peer educators from among their client populations. However, not everyone is an educator. The model client does not necessarily make the model teacher, no matter how

consistently s/he practices HIV/AIDS risk reduction or is liked by agency staff. Peer educators should be instinctive communicators. They should be empathetic and non-judgmental. They should also be committed to client confidentiality.

Peer educators will not replace an agency's professional health educators, but they can complement the intervention team and enhance intervention efforts. Peer educators may act as support group leaders or street outreach volunteers who distribute materials to friends. They may be members of an agency's speaker's bureau and give workshop presentations.

They may run shooting galleries, keeping bleach and clean water readily available to other (IDUs). They may be at-risk adolescents who model responsible sexual behaviors. The role of the peer educator is determined by the intervention need of the client population and the skill of the peer educator.

Although some agencies will hire peer educators as paid staff, others will not. As in the case of speaker's bureaus, engaging volunteer peer educators also involves issues of volunteer recruitment, training, and retention. Several references in the list of publications included at the end of this document provide more information on this issue. In addition to the core elements identified for health education and risk reduction activities, an effective peer education program plan contains the following:

- A written and comprehensive field safety protocol (see sample below).
- A description of skills building exercises relevant to the stated program objectives.

Sample – Field Safety Protocol for Outreach Workers

Field safety protocols are based on program activities and are intended to provide the staff and peer educators with guidance regarding their professional behavior.

- Carry picture identification (I.D.) at all times that includes name of the organization, name of the project, your name, and the purpose for your presence.
- Work in pairs and always know where your partner is.
- Establish a mechanism to keep your supervisor aware of your location and activities.
- Establish contact with local police precincts in the area. If appropriate for your program, maintain relations with the police; introduce the program and staff.
- Have contingency plans for worst case scenarios and share them with your partner.
- Make sure you have made contact with and have permission from a key person in the community before entering the setting in which you will conduct the intervention (e.g., bars, shooting galleries, crack houses, or local high schools).
- Leave the area if tension or violence is observed or perceived.
- Avoid controversy and debate with clients and program participants.
- Adhere to a schedule for outreach or peer education.
- Avoid drinking alcoholic beverages and buying, receiving, or sampling drugs while conducting outreach or peer education.

Prevention Case Management (PCM)

Prevention Case Management (PCM) is a client-centered HIV prevention intervention with the fundamental goal of promoting the adoption of HIV risk-reduction behaviors by clients with multiple, complex problems and risk-reduction needs. It is a one-on-one client service intended to assist both un-infected persons and those living with HIV who are having or likely to have difficulty initiating or sustaining practices that reduce or prevent HIV transmission and acquisition.

PCM is a hybrid of HIV risk-reduction counseling and traditional case management. It provides an ongoing, sustained relationship with the client in order to assure multiple-session, individualized HIV risk reduction counseling that provides intensive support and referrals to medical, psychological and other services.

The goal of PCM is to assist persons to remain seronegative or to reduce the risk for HIV transmission to others by those who are HIV-positive. PCM is intended for persons who are having or who are likely to have difficulty initiating and sustaining safer behavior.

The **standards** for PCM are included in the following document, the CDC **Guidance** for PCM.

Prevention Case Management - Guidance

Centers for Disease Control & Prevention
National Center for HIV, STD, and TB Prevention
Divisions of HIV/AIDS Prevention
Updated: January 26, 1998

1.0 INTRODUCTION

1.1 HISTORY

This guidance is offered to assist state and local health department human immunodeficiency virus (HIV) prevention cooperative agreement grantees and directly funded community-based organization (CBO) grantees in planning, implementing, and evaluating HIV prevention case management (PCM). The Centers for Disease Control and Prevention (CDC) provides funding for individual-level, health education and risk-reduction activities, which include PCM. Previous guidelines for PCM are published in Guidelines for Health Education and Risk-Reduction Activities, U.S. Department of Health and Human Services, April 1995. This revised guidance supersedes the 1995 PCM guidelines by further detailing essential components and protocols for PCM programs. (A glossary of terms is provided in Appendix A to assist the reader.)

HIV PCM is a client-centered prevention activity, which assists HIV seropositive and seronegative persons in adopting risk-reduction behaviors. PCM is intended for persons having or likely to have difficulty initiating or sustaining practices that reduce or prevent HIV transmission and acquisition. PCM provides intensive one-on-one prevention counseling and support. In addition, PCM provides assistance in accessing needed medical, psychological, and social services that affect clients' health and ability to change HIV-related risk-taking behavior.

Important issues have emerged from the experiences of those implementing the first PCM programs. As a result of questions about the range of services appropriate for PCM, the type and extent of counseling, and staffing qualifications, CDC staff believes revising programmatic guidance for this activity is important. This guidance provides minimum standards for PCM programs. Individual jurisdictions may develop more specific PCM standards for their own locale that go beyond the minimum standards specified in this document.

These standards and guidance for PCM were established after consultation among experts from HIV prevention programs, academia, and CDC. This revised guidance is also based on a literature review of the existing research (CDC 1997) and a systematic review of PCM programs [Purcell, DeGroff, and Wolitski, Submitted for Publication]. The experiences of organizations implementing PCM over the past three to five years have provided valuable information on which to base this revised guidance. Little outcome evaluation of PCM has been conducted; therefore, CDC bases this guidance, in part, on the review of research of other case management models.

1.2 TENETS OF PCM

This guidance is based on the following tenets and assumptions:

- The fundamental goal of PCM is HIV primary prevention - preventing the transmission or acquisition of HIV.
- Early identification of HIV infection enables individuals to make informed decisions about their own health.
- The primary goals in working with clients are self-determination and self-sufficiency
- High standards for PCM will improve the outcomes for clients.

- PCM is guided by the same broadly accepted professional standards adhered to by other human service professionals such as social workers, counselors, and clinical psychologists.

1.3 STANDARDS AND GUIDANCE

The standards and guidance in this document describe the core elements that are essential for success in planning, implementing, and evaluating a PCM program. They are provided to assist program planners in enhancing their PCM programs and state and local health department personnel who are funding PCM programs. Agencies receiving CDC funds to support PCM program(s) should follow the standards and guidance contained within this document. Agency staff interested in diverting from this guidance should first seek the advice of their state or local health department or CDC project officer. Organizations using funds other than CDC monies to support PCM activities should consider using this document as a guide.

The two levels of recommendations this document provides are as follows:

Standards: Specific standards are provided in several sections in boxed text .These standards should be applied consistently to the delivery of PCM services. They must be followed in virtually all cases. Appendix B provides a comprehensive listing of all PCM standards.

Guidance: The main text of this document provides overall program guidance in developing, implementing, and evaluating PCM programs. The overall guidance should be followed in most cases. CDC recognizes that, depending on the client population, setting, and other factors, the overall guidance can and should be tailored to fit individual program needs.

1.4 GOALS OF PCM

The goals of a PCM program are as follows:

- To provide specialized assistance to persons with multiple and complex HIV risk-reduction needs;
- To provide individualized, multiple-session HIV risk-reduction counseling to help initiate and maintain behavior change to prevent the transmission or acquisition of HIV;
- To assess risks of other sexually transmitted diseases (STDs) and ensure appropriate diagnosis and adequate treatment;
- To facilitate referral services for clients' medical and psychosocial needs that affect their health and ability to change HIV-related risk-taking behavior; and
- To provide information and referrals for HIV secondary prevention needs of persons living with HIV or acquired immunodeficiency syndrome (AIDS).

2.0 DEFINING PCM

2.1 WORKING DEFINITION OF PCM

PCM is a client-centered HIV prevention activity with the fundamental goal of promoting the adoption and maintenance of HIV risk-reduction behaviors by clients with multiple, complex problems and risk-reduction needs. PCM is intended for persons having or likely to have difficulty initiating or sustaining practices that reduce or prevent HIV acquisition, transmission, or reinfection. As a hybrid of HIV risk-reduction counseling and traditional case management, PCM provides intensive, on-going, individualized prevention counseling, support, and service brokerage. This HIV prevention activity addresses the

relationship between HIV risk and other issues such as substance abuse, STD treatment, mental health, and social and cultural factors.

Priority for PCM services should be given to HIV seropositive persons having or likely to have difficulty initiating or sustaining practices that reduce or prevent HIV transmission and reinfection. For HIV seropositive persons, PCM involves the coordination of primary and secondary prevention interventions in close collaboration with Ryan White CARE Act case management providers (See Appendix C for fact sheet on Ryan White CARE Act). Further, PCM ensures the provision of other medical and psychosocial services affecting risk behavior, including STD and substance abuse treatment services.

HIV seronegative persons, or those of unknown HIV serostatus - either (1) engaging in high-risk behavior within communities with moderate to high seroprevalence rates of HIV infection or (2) otherwise at heightened risk of infection - may also be appropriate for PCM.

PCM includes the following seven essential components (See Section 4.2 for further details):

1. Client recruitment and engagement;
2. Screening and assessment (comprehensive assessment of HIV and STD risks, medical and psychosocial service needs - including STD evaluation and treatment, and substance abuse treatment);
3. Development of a client-centered "Prevention Plan;"
4. Multiple-session HIV risk-reduction counseling;
5. Active coordination of services with follow-up;
6. Monitoring and reassessment of clients' needs, risks, and progress; and
7. Discharge from PCM upon attainment and maintenance of risk-reduction goals.

2.2 DIFFERENTIATING PCM FROM OTHER HIV RISK-REDUCTION ACTIVITIES

PCM is conceptualized as a highly individualized and intensive HIV risk-reduction strategy. PCM is intended for persons at greatest risk of transmitting or acquiring HIV whose needs are not being effectively served and whose behavior is not influenced by less intensive HIV prevention interventions, such as street outreach, group-level strategies, or HIV counseling and testing. PCM is considered an individual-level HIV prevention activity and does not typically include group or community-level strategies. Characteristics of PCM differentiate it from these other prevention activities. PCM characteristics include the following:

- The formal enrollment of "clients" into an on-going service guided by professional standards.
- The development of a formal relationship between a prevention case manager and a client, a relationship that is characterized by active, cooperative prevention planning, problem solving, counseling, and referral provision.
- In-depth, on-going, risk-reduction counseling that addresses specified behavioral objectives.
- The need for professional staff skills to conduct most functions of PCM, including assessment, prevention planning, and risk-reduction counseling.

These characteristics of PCM are in contrast to other prevention activities such as street and community outreach and risk-reduction groups in which staff or volunteers, often peers or paraprofessionals, may interact on a brief or limited basis with high-risk individuals. The relationship of PCM to other individual-level HIV prevention activities is illustrated in Figure 1.

Finally, PCM is likely to be more costly than most other HIV prevention activities that employ peers or paraprofessionals to reach larger numbers of people with less time-intensive, staff-intensive risk-reduction strategies (See Section 4.3 for more detail about staff qualifications). However, PCM is likely to be cost

beneficial because it emphasizes serving persons with particular difficulty changing behavior and most likely to transmit or acquire HIV.

Figure 1

Street Outreach	**HIV Counseling And Testing**	**Prevention Case Management**
Low Intensity	*Moderate* Intensity	*High* Intensity
Short Duration	*Short* Duration	*Long* Duration
Potential to Reach *High* Number of People	Reaches *Moderate* Number of People	Reaches *Low* Number of People
Low Cost per Person	*Moderate* Cost per Person	*High* Cost per Person
Peers or *Paraprofessional* Staff	*Paraprofessional* or *Professional* Staff	Primarily *Professional* Staff

2.3 DIFFERENTIATING PCM FROM OTHER FORMS OF CASE MANAGEMENT

Case management is widely acknowledged to be an important psychosocial strategy with potential for addressing a wide range of social ills (Rothman 1992). The fundamental principles underlying case management services are that case managers (1) facilitate linking clients to the complex delivery system and (2) help to enable clients, through psychosocial interventions, to benefit from appropriate services. For persons living with HIV and AIDS, case management has emerged as the prominent strategy for coordinating the wide range of needed health care, psychiatric, psychosocial, and practical support services (Mor, Piette, and Fleishman 1989). Although researchers and clinicians have been unable to agree on one widely accepted definition of case management (Baldwin and Woods 1994; GrHAAm and Birchmore-Timney 1990; and Piette, Fleishman, Mor, and Dill 1990), most might agree with the following broad definition of case management:

" . . . The provision for some greater continuity of care through periodic contact between case manager(s) and the client that provides greater (or longer) coordination and brokerage of services than the client could be expected to obtain without case management" (Orwin et al. 1994, p. 154).

Although PCM also provides greater continuity of care, it is specifically focused on HIV-related behavior change. PCM involves the identification of HIV risk behaviors and medical and psychosocial needs that influence HIV risk taking followed by the development of a client-centered Prevention Plan with specific behavioral objectives for HIV risk reduction. Through both direct and facilitative service provision, PCM provides primary and secondary HIV prevention services and facilitates the provision of other medical and psychosocial services affecting risk behavior, including STD evaluation and treatment and substance abuse treatment. HIV primary prevention aims to reduce the transmission and acquisition of HIV infection, whereas HIV secondary prevention aims to prevent a person living with HIV from becoming ill or dying as a result of HIV-related illness and opportunistic infections (Last and Wallace 1992).

The foundation of PCM involves multiple-session risk-reduction counseling in which a variety of strategies are applied by the prevention case manager to influence HIV risk behavior change. Like case management, prevention case managers broker needed medical and psychosocial services, specifically those that influence HIV risk-taking such as STD and substance abuse treatment, thereby providing more

efficient coordination of services. For example, an injecting drug user may have difficulty benefiting from HIV risk-reduction counseling without receiving substance abuse treatment.

3.0 DEVELOPING AND PLANNING A PCM PROGRAM

3.1 ORGANIZATIONAL CONTEXT AND CAPACITY

Factors related to organizational context and capacity may influence the potential effectiveness of a PCM program. These factors include the organization's physical setting, staffing capacity and skills, referral tracking capabilities, and the availability of, and access to, local referral sources.

PCM may be implemented from a variety of institutional or community-based settings. A review of PCM programs suggests, however, that "stand-alone" PCM programs - those programs independent of other preventive, medical, or social services, for example, health care, substance abuse treatment, and residential housing - have had more difficulty recruiting and retaining PCM clients [Purcell, DeGroff, Wolitski, Submitted for Publication]. PCM programs that are well integrated within a larger continuum of drug treatment, STD treatment, health care, or other social services may be more effective in recruiting and retaining clients. Thus, agencies that provide a spectrum of services and have strong relationships and/or alliances with outside providers in the community may be well positioned to support a PCM program, whereas "stand-alone" programs - those independent from other preventive, medical, or social services - are discouraged from considering a PCM program.

Second, the skills and capacity of staff are especially important for many of the services PCM programs provide. Prevention case managers require a broad array of sophisticated skills including assessment, prevention service planning, risk-reduction counseling, and crisis counseling. PCM targets those individuals with multiple, complex problems and risk-reduction needs; consequently, sophisticated skills are required of staff for some tasks (See Section 4.3 for more detail about staff qualifications).

Third, referral-tracking systems, computerized or otherwise, should be implemented to evaluate the effectiveness of a PCM program's referral system. This implies a level of organizational capacity to establish and confidentially maintain such a system.

Finally, the case management literature suggests that giving consideration to the available network of community support programs is important (Rubin 1992). The effectiveness of case management in general is related to both the availability of referral sources in the community and to supportive structural factors in the agency itself and the larger community system (Rothman 1992). Therefore, agencies considering a PCM program should first assess the availability of community services relevant to the target population and then evaluate their ability to develop and implement referral systems.

All these factors should be considered in determining whether or not your agency and community has the capacity to effectively support a PCM program.

3.2 DEVELOPING AN ORGANIZATION'S PROGRAM PLAN FOR PCM

3.2.1 HIV Prevention Community Planning

In 1994, the 65 state and local health departments that received CDC federal funds for HIV prevention began a participatory HIV prevention planning process. The goal of HIV prevention community planning is to improve the effectiveness of HIV prevention programs by strengthening the scientific basis, targeting, and community relevance of HIV prevention interventions. Together, representatives of affected populations, epidemiologists, behavioral scientists, HIV/AIDS prevention service providers, health department staff, and others analyze the course of the epidemic in their jurisdiction, determine their priority

prevention needs, and identify HIV prevention interventions to meet those needs. Community planning groups are responsible for developing comprehensive HIV prevention plans that are directly responsive to the epidemics in their jurisdictions.

To proceed in developing a PCM program, the intended target population and PCM as an intervention should be consistent with the HIV prevention priorities identified in a jurisdiction's comprehensive HIV prevention plan.

3.2.2 Needs Assessment

In developing and planning a PCM program, a needs assessment is an essential first step. The needs assessment will assist in (1) establishing appropriate goals and objectives; (2) defining the purpose and scope of the program; (3) identifying social and behavioral attitudes, behaviors, and perceptions of the target community; (4) providing the basis for evaluation; and (5) establishing community-based support for the PCM program. This assessment should augment the epidemiologic profile and needs assessment described in the jurisdiction's comprehensive HIV prevention plan by providing additional, specific information needed for program design and implementation. These population characteristics will influence the range of PCM activities provided, the case manager's caseload, and recruitment and delivery strategies for a program. [More detailed information on conducting a needs assessment can be found in "Chapter 5: Assessing and Setting Priorities for Community Needs," Handbook for HIV Prevention Community Planning, Academy for Educational Development, April 1994. State and local health department program managers will also find information on conducting needs assessment in Planning and Evaluating HIV/AIDS Prevention Programs in State and Local Health Departments: A Companion to Program Announcement 300, Centers for Disease Control and Prevention, Reissued October 1996.]

3.2.3 Assessment of Community Resources

An assessment of community resources, including other HIV prevention programs and diagnosis and treatment services for substance abuse and for other STDs, is also essential - Results may influence the range of services provided by a PCM program and the skills needed by program staff. For instance, if a program is serving injecting drug users and few substance abuse treatment and prevention services are available, having program staff that is well trained in a variety of harm-reduction strategies is important. In other words, a PCM program should be tailored to the needs and characteristics of the population to be reached as well as to the available community services.

3.2.4 Goals and Objectives

A detailed program plan should be written that includes specific, time-phased, and measurable objectives for the PCM program. This plan should clearly define the goals and boundaries of the PCM program, including the roles to be assumed by prevention case managers. This has implications for staff training and resources. The plan should detail all parts of the PCM program including quality assurance and process evaluation measures.

4.0 IMPLEMENTING A PCM PROGRAM

4.1 CLIENT ELIGIBILITY

PCM is primarily intended for persons with multiple, complex problems and risk-reduction needs who are having or likely to have difficulty initiating or sustaining practices that reduce or prevent HIV acquisition, transmission, or reinfection. Priority for PCM services should be given to HIV seropositive persons. An agency may also serve HIV seronegative persons or those of unknown HIV serostatus if the individual identified for PCM is (1) a member of a community with moderate to high seroprevalence rates of HIV infection or (2) otherwise at heightened risk of HIV infection.

The following population groups are examples of those who may be appropriate for PCM, providing they meet the eligibility criteria just detailed (NOTE: This list is neither exclusive nor exhaustive):

1. Persons recently identified as HIV-infected by counseling and testing sites or partner notification services;
2. Partners of HIV-infected persons identified through referral or partner notification services;
3. Clients in substance abuse treatment or injecting drug users out of treatment who are accessing syringe exchange or harm-reduction programs.
4. Men who have sex with men (MSM), including young MSM;
5. Adults and teens repeatedly infected with STDs, especially HIV-positive persons, identified at health or STD clinics;
6. Clients of tuberculous (TB) clinics;
7. Adults recently released from corrections facilities with a history of substance abuse; and
8. Discordant couples with inconsistent condom use.

PCM program staff should emphasize the benefits of participation to potential clients, including assistance in identifying and addressing barriers to HIV risk reduction and assistance in accessing health and social services. Although some persons may present with a variety of acute medical and psychosocial needs, PCM is a voluntary service and should be reserved for individuals with a willingness to discuss their personal risk for HIV and to participate in HIV risk-reduction counseling on a regular basis. A review of PCM programs suggests that HIV seropositive persons may have stronger interest in participating in PCM programs. This review also finds that engaging high-need clients in HIV prevention activities, regardless of HIV serostatus, is difficult [Purcell, DeGroff, Wolitski, Submitted for Publication].

4.2 ESSENTIAL COMPONENTS OF A PCM PROGRAM

Each of the seven essential components of a PCM program is described in detail in the following sections.

4.2.1 Client Recruitment and Engagement

Each PCM program must have a comprehensive plan that contains explicit protocols to recruit and engage clients for PCM. Making a PCM program well known and visible for those persons the program intends to serve is important. Recruitment strategies might include:

(6) enlisting the assistance of a street outreach program serving a similar target population to identify potential PCM clients;

(7) recruiting recently identified HIV seropositive persons from a counseling and testing site or partner notification service; or

(8) recruiting clients from other programs such as an STD clinic, a women's health clinic, or a drug treatment program.

In some cases, programs have used various incentives (for example, bus tokens, hygiene kits, tee shirts, and so on) to enhance recruiting efforts [Purcell, DeGroff, Wolitski, Submitted for Publication].

Acting quickly and early in the PCM process is important. Research shows that effective outreach and intake efforts are associated with a quick response time and assertive follow-up, a fact that has important implications for successful client recruitment in case management (Rothman 1992). For example, to ensure initial engagement in PCM, a program may require staff to follow up with each client a minimum of three or four times within the first 30 days, two of which must be in person.

STANDARD for Client Recruitment and Engagement

Protocols for client engagement and related follow-up must be developed, such as requiring a minimum number of follow-up contacts within a specified time period.

4.2.2 Screening and Assessment

To maximize staff resources, potential PCM clients must be initially screened to ensure their eligibility for the service. Screening may include assessing risk behavior, intention, or readiness to change risk behavior (Prochaska and DiClemente 1992; Ajzen and Fishbein 1980). Case managers should also assess, over the course of the first three to four PCM sessions, a client's willingness and ability to participate in HIV risk-reduction counseling. If a potential client is found ineligible for PCM services, counseling and referrals relevant to their needs must be provided.

The need for a thorough assessment of clients' HIV, STD, and substance abuse risks, along with their medical and psychosocial needs, is essential for PCM. Assessment should identify behavioral factors that increase the risk for infection or transmission of HIV and other STDs. Assessment should also include the determination of whether or not the client has been HIV antibody tested and the client's knowledge of his or her HIV serostatus. The case manager should engage the client in a discussion that enables the client to recognize and accept personal risk for HIV. A client-centered approach to assessment is essential - the approach should be thorough and individualized for each client. Case managers should develop effective interactive methods to involve the client in identifying risk behaviors.

To provide the case manager with a more complete understanding of each client's medical and psychosocial needs and the overall context in which HIV risk behavior occurs, the following items should be assessed: health; adherence to HIV-related treatment; STD history; substance and alcohol use; mental health; sexual history; social and environmental support; skills to reduce HIV risk; intentions and motivations; barriers to safer behaviors; protective factors, strengths, and competencies; and demographic information. When combined, assessment activities should yield a comprehensive picture of the client's HIV prevention needs (PROCEED, Inc. 1997).

Case managers must provide clients a copy of a voluntary informed consent document for signature at the time of assessment. This document must assure the client of confidentiality (See Section 6.0, Ethical and Legal Issues).

Potential areas for assessment include the following:

Health This assessment should address access to medical care; current or chronic health conditions; HIV serostatus; date of last HIV antibody test; history of HIV-related opportunistic infections; date of last TB test; TB status; and, for women, date of last gynecological exam, birth control methods, and pregnancy history.

Adherence to HIV-Related Treatment For persons living with HIV and receiving drug treatment, the assessment should address issues related to adherence to HIV-related treatment. Although new antiretroviral therapies have shown tremendous clinical benefit, ongoing concerns about adherence to complicated drug regimens and the likelihood of antiretroviral drug resistance are serious issues that must be actively addressed by prevention case managers. Areas for assessment within this category include adherence to antiretroviral therapies, adherence to treatments for opportunistic infections, barriers to adherence, factors facilitating adherence, and ability and intention to follow complex treatment regimens.

STD History The prevention, diagnosis, and treatment of STDs other than HIV is an essential component of any PCM program. The sequelae of untreated STDs can be serious. Untreated chlamydia and gonorrhea are two major contributors to preventable tubal infertility. Furthermore, acute STDs, particularly those involving lesions on the skin or mucous membrane, facilitate the transmission of HIV. Therefore, clients' history and treatment of STDs should be assessed as well as the date of their last STD medical evaluation.

Substance and Alcohol Use A number of factors related to substance and alcohol use should be assessed including the following: history of injecting drugs, alcohol use, and other non-injecting drug use; drug(s) of choice; frequency of use; route of administration; length of time using drugs/alcohol; frequency of needle sharing; treatment history; psychosocial context of drug/alcohol use; and affect of drug/alcohol use on sexual behavior. The potential relationship between substance use and unsafe sexual behaviors highlight the need for a comprehensive assessment of both injecting and non-injecting drugs.

Mental Health Several factors related to mental health should be considered including the following: family and personal mental health history; history of treatment, therapy, and hospitalization; adherence to treatment; suicidal ideation and history; and psychotropic medication history.

Sexual History A comprehensive sexual history is necessary to fully assess sexual risk behavior and related factors. Areas for assessment include number of sex partners; current partners (nature of relationships); HIV serostatus of partners; sexual behaviors practiced and frequency of behaviors; history of sexual abuse; role of alcohol and drugs during sex; involvement in sex in exchange for drugs/money/and so on; risk behaviors of partners; condom use, including barriers and facilitating factors for condom use; and knowledge of safer sex practices.

Social and Environmental Support Assessing key factors related to social and environmental support will provide a prevention case manager a more comprehensive picture of the context within which a client engages in risk behavior and of external factors potentially influencing risk behavior. Areas for assessment include the following: living situation; economic status; sources of income; employment; in or out of school, if youth; emotional support sources; history of incarceration; significant others; and connections to the community, for example, friends, family, church, and service providers.

Skills to Reduce HIV Risk Prevention case managers should assess the level of client skills in areas such as the following: use of condoms; sexual assertiveness; use of needle and syringe sterilization methods; use of safer injecting skills; and communication and negotiation skills.

Barriers to Safer Behavior A careful assessment of clients' perceived barriers to safer behavior is essential. Potential barriers include the following: knowledge of risk associated with unprotected intercourse and using unclean shared filters, cookers syringes water; availability of, and willingness to use, condoms and sterile syringes and injection equipment; potential for violence; legal concerns; cognitive or perceptual barriers; and personal and/or cultural barriers - values and norms around sexuality, drug use, or gender roles that affect risk behavior.

Protective Factors, Strengths, and Competencies Resources and factors that facilitate client's ability to stay healthy and practice safer behaviors should be assessed.

Demographic Information Basic demographic information should be collected including age, gender, race/ethnicity, sexual orientation, and education.

STANDARDS For Screening and Assessment

- PCM program staff must develop screening procedures to identify persons at highest risk for acquiring or transmitting HIV and who are appropriate clients for PCM.
- All persons screened for PCM, including those who are not considered to be appropriate for PCM, must be offered counseling by the prevention case manager and referrals relevant to their needs.
- Thorough and comprehensive assessment instrument(s) must be obtained or developed to assess HIV, STD, and substance abuse risks along with related medical and psychosocial needs.
- All PCM clients must participate in a thorough client-centered assessment of their HIV, STD, and substance abuse risks and their medical and psychosocial needs.
- Case managers must provide clients a copy of a voluntary informed consent document for signature at the time of assessment. This document must assure the client of confidentiality.

4.2.3 Development of a Client-Centered Prevention Plan

A written client-centered Prevention Plan, based on information compiled from the assessment, must be developed. This plan should identify behavioral objectives to reduce the risk of acquiring or transmitting HIV that are time-phased, specific, and achievable. The client should establish both short- and long-term goals with the assistance of the case manager. Client participation is key because many clients are well aware of their goals and what would help them meet those goals (Rothman 1992). A client-centered approach will ensure that the Prevention Plan is responsive to the individual client's needs and circumstances. Therefore, prevention case managers should actively engage the client in setting behavioral objectives and identifying change strategies.

The Prevention Plan should identify effective change strategies that are reasonable and manageable for the client given his or her skills and circumstances. The Prevention Plan should specify who will be responsible for what and when (PROCEED, Inc. 1997). A high degree of specificity about the behaviors targeted for change, the interventions needed to implement change, and the expected outcomes should be included in the Prevention Plan.

For persons living with HIV and receiving medical treatments, secondary prevention interventions must focus on ensuring adherence to treatment for opportunistic infections and adherence to complex antiretroviral combination therapies. Secondary prevention interventions should also focus on maintaining the health of the client by ensuring the procurement of needed legal and entitlement services, treatment education, information on clinical care, and mental health services. The PCM Prevention Plan should detail the client's involvement, if eligible, in Ryan White CARE Act case management services along with other related programs or services. Further, the Prevention Plan should document efforts to ensure coordination and/or integration of PCM and Ryan White CARE Act case management.

The Prevention Plan must also outline efforts to ensure that a PCM client is medically evaluated for STDs at regular intervals regardless of symptom status. This will require that PCM programs establish a

strong relationship and referral mechanism with local STD service providers. As noted earlier in this document, the sequelae of untreated STDs can be serious and include infertility.

For clients with substance abuse problems, the Prevention Plan must address referral to appropriate drug and/or alcohol treatment. This will require that PCM programs establish strong relationships with local substance abuse providers if these services are not provided in-house. As discussed earlier in this document, the relationship between substance use and unsafe sexual behavior highlights the importance for securing appropriate treatment for those who need it. Furthermore, a substance-abusing client benefiting from HIV risk-reduction counseling without having received substance abuse treatment is unlikely.

Finally, client files that include individual Prevention Plans must be maintained in a locked file cabinet to ensure confidentiality.

STANDARDS for Development Of A Client- Centered Prevention Plan

- For each PCM client, a written Prevention Plan must be developed, with client participation, which specifically defines HIV risk-reduction behavioral objectives and strategies for change.
- For persons living with HIV and receiving antiretroviral or other drug therapies, the Prevention Plan must address issues of adherence.
- The Prevention Plan must address efforts to ensure that a PCM client is medically evaluated for STDs at regular intervals regardless of symptom status.
- For clients with substance abuse problems, the Prevention Plan must address referral to appropriate drug and/or alcohol treatment.
- Clients must sign-off on the mutually negotiated Prevention Plan to ensure their participation and commitment.
- Client files that include individual Prevention Plans must be maintained in a locked file cabinet to ensure confidentiality.

4.2.4 HIV Risk-Reduction Counseling

4.2.4.1 Client-Centered Counseling

Client-centered HIV risk-reduction counseling (that is, reducing the risk of acquiring or transmitting HIV) is the foundation of PCM. Client-centered counseling refers to counseling conducted in an interactive manner responsive to individual client needs (U.S. Department of Health and Human Services, May 1994). With a focus on meeting the identified behavioral objectives specified in the Prevention Plan, case managers must work with the client and apply a variety of strategies over multiple sessions to influence HIV risk behavior change. Depending on a client's readiness to change (Prochaska and DiClemente 1992), case managers should intervene to influence knowledge, perceived risk and vulnerability, intentions to change behavior, self-efficacy, skill levels, environmental barriers, relapse, and social support. Specific interventions for clients, regardless of HIV serostatus, may include skills building, individual counseling, couples counseling, crisis management, resource procurement, and preparation for referral of partners.

Counseling should be specifically tailored to the risk-reduction needs of each client. Table 1 summarizes factors that influence HIV risk behavior change (PROCEED, Inc. 1997 and Kelly 1992).

For persons of unknown HIV serostatus, interventions to prepare the client for HIV antibody testing may be appropriate. All clients must receive information regarding the potential benefits of knowing one's HIV serostatus. Counseling should explore barriers to testing faced by the client and seek to identify strategies to overcome these barriers. For individuals to make informed decisions about their health, early identification of HIV infection is important.

As part of client-centered counseling, PCM clients must be provided education about the increased risk of HIV transmission associated with other STDs and about the prevention of these other STDs. This counseling should also address the need for regular medical evaluation for STDs.

Finally, for seropositive clients, prevention case managers must discuss the notification of sex and needle-sharing partners who have been exposed to HIV. The purpose of notifying partners is to make them aware of their exposure to HIV and assist them in gaining access to counseling, testing, and other prevention and treatment services, including PCM, earlier in the course of infection (West and Stark 1997).

PCM program staff must develop a protocol for assisting seropositive clients in confidentially notifying partners and referring them to PCM and/or counseling and testing services. Two major approaches to partner notification have traditionally been applied by STD and HIV programs. Patient referral, when the patient or client notifies and refers his or her own sex and/or needle-sharing partners for testing, and provider referral, when health professionals, usually from the health department, notify the patient's partners of their exposure. Protocols for partner notification, within the context of PCM, should address the need for this service and be implemented at PCM enrollment or at any time clients potentially expose others while participating in the PCM program.

When clients choose to notify their own partners, prevention case managers should provide them with needed counseling, support, and skill building to ensure the successful confidential notification and referral of partners. Prevention case managers may invite clients to bring their partners to a PCM session, once notified, to provide partner counseling and ensure appropriate referrals to testing. Referral for medical evaluation and treatment of other STDs should be offered to all partners.

If the PCM client is unable or unwilling to notify partners himself/herself, the prevention case manager may facilitate notification by eliciting partner names and locating information and then, with the client's permission, requesting health department officials to confidentially notify partners. This approach requires that PCM programs establish an explicit relationship with health department officials to jointly carry out partner notification services. PCM program staff should be familiar with the health department's procedures for confidentially notifying partners and explain this process to clients. Finally, PCM programs may refer the client directly to the health department for assistance. Regardless of the approach used, partners identified may benefit from PCM services and should be assessed to determine their eligibility for the service.

Factor	Description	Elements of Effective Intervention
Knowledge About Risk	Accurate understanding of behaviors that confer risk, behavior changes needed to reduce risk, and the rationale underlying risk-reduction changes	Clear identification of behavior practices that create risk; practical advice on behavior changes needed to reduce risk, taking into account the realities of the client's lifestyle and relationships
Perceived Personal Vulnerability	Personalization of risk; believing one-self to be potentially vulnerable for contracting HIV/AIDS	Discussion that accurately communicates the client's risk level, encourages the client's self-appraisal of risk, and induces realistic perception of threat
Behavior Change Intention	Readiness for change and committing oneself to risk-reduction effort	Assessing, together with the client, his or her readiness for change and setting achievable risk-reduction goals through counseling and/or contracting
Self-Efficacy	Believing oneself capable of success-fully making risk-reduction behavior changes and perceiving that this change will protect against HIV/AIDS	Assigning incremental risk-reduction "tasks" that can easily be accomplished to establish a sense of competency and a success record; counseling that challenges a client's sense of fatalism
Skill Level	Behavioral competence in areas necessary for change implementation including condom use or other safer sex practices; sexual assertiveness skills to refuse risk pressures; safer sex negotiation skills; not sharing needles; use of clean needles; etc.	Skills training and practice; self-management or identification of patterns, habits, or activities that increase vulnerability to risk and development of alternative plan to address these behavioral "triggers"
Reinforcement of Behavior Change Efforts	Positive rather than negative outcomes associated with behavior change efforts, including positive partner response, self-praise, and reinforcement; belief that behavior change is consistent with peer group norms	Follow-up counseling contracts that suggest and reinforce change efforts, discussion of problems encountered, and encouragement of self-praise of risk-reduction change
Environmental Barriers	Experience fewer environmental constraints to perform a behavior rather than not to perform it	Discussion of barriers to performing risk-reduction behaviors; development of strategies to overcome those barriers and to create easier access to the resources required to enact change

Original table published by J. A. Kelly, "AIDS Prevention: Strategies That Work," AIDS Reader, July/August 1992, pp. 135–141; adapted with permission from version published by PROCEED, Inc., Standards and Considerations for Establishing HIV Prevention Case Management, 1997.

4.2.4.2 Partner Counseling

Including the client's partner in risk-reduction counseling sessions is appropriate within the context of PCM.

4.2.4.3 Secondary Prevention Counseling

Although PCM always involves primary prevention risk-reduction counseling, counseling related to secondary prevention for persons living with HIV is also appropriate within PCM. For instance, clients may need counseling support for accessing medical care and treatment. For persons receiving treatment for opportunistic infections and/or antiretroviral therapy(ies), counseling to support adherence to these treatments/therapies must be provided.

4.2.4.4 Substance Abuse and Mental Health Counseling

Although the emphasis of PCM is on HIV risk-reduction counseling, in some instances, some substance abuse and/or mental health counseling may need to be provided. In fact, counseling about strategies to avoid or modify substance abuse behaviors can be a form of HIV risk-reduction counseling. Such counseling should only be provided by staff skilled in these areas. Referring clients with these counseling needs to agencies with specific expertise in substance abuse and mental health counseling is optimal. However, if such services are unavailable and PCM staff has appropriate skills, short-term counseling focused on immediate living problems may be appropriate. Rothman (1992) found that counseling provided within case management is more effective when focused on information sharing, problem solving, reality testing, and socialization skills. PCM should not substitute for long-term therapy focused on long-standing personality issues or serious mental illness.

STANDARDS For HIV Risk-Reduction Counseling

- Multiple-session HIV risk-reduction counseling aimed at meeting identified behavioral objectives must be provided to all PCM clients.
- Training and quality assurance for staff must be provided to ensure effective identification of HIV risk behaviors and appropriate application of risk-reduction strategies.
- Clients who are not aware of their HIV antibody status must receive information regarding the potential benefits of knowing their HIV serostatus.
- Clients must be provided education about the increased risk of HIV transmission associated with other STDs and about the prevention of these other STDs.
- PCM program staff must develop a protocol for assisting HIV seropositive clients in confidentially notifying partners and referring them to PCM and/or counseling and testing services. For persons receiving treatment for opportunistic infections and/or antiretroviral therapy(ies), counseling to support adherence to treatments/therapies must be provided.

4.2.5 Coordination of Services with Active Follow-Up

The PCM program must establish a procedure for referring persons in a timely, efficient, and professional manner to sites providing services that may facilitate a client's ability to address and reduce his or her HIV risk behavior (for example, medical services, psychological treatment, substance abuse treatment, STD treatment, social services, and other HIV prevention services). Collaborative relationships should be established with appropriate representatives of referral sites. PCM staff should actively assist

clients in securing services at referral sites. Such assistance may include accompanying a client to an appointment, providing transportation services or bus/rail tokens, ensuring the provision of child-care services, ensuring translation or interpretation services, and providing client skills-building to support his/her ability to effectively advocate on behalf of himself/herself with other providers.

Effective coordination of services necessitates that PCM programs have current, accurate community provider information on hand. This information should include hours of operation, addresses, phone numbers, accessibility to public transportation, eligibility requirements, and information regarding materials required at application such as bringing a driver's license, birth certificate, and so forth.

Most PCM clients may be already receiving services from other providers. Therefore, coordination of services also involves collaboration with an individual client's other case managers or counselors (for example, substance abuse counselor, Ryan White CARE Act case manager, probation officer, or housing or shelter supervisor). Such collaboration benefits the client and avoids duplication of services. Communication about an individual client with other providers is dependent upon the obtainment of written, informed consent from the client.

Finally, PCM program staff must have methods in place to follow up on referrals to assess the outcome, for example, whether or not the client received the needed service.

STANDARDS for Coordination of Services with Active Follow-Up

- Formal and informal agreements, such as memoranda of understanding, must be established with relevant service providers to ensure availability and access to key service referrals.
- A standardized written referral process for the PCM program must be established.
- Explicit protocols for structuring relationships and communication between case managers or counselors in different organizations is required to avoid duplication of services, for example, how to transfer or co-manage PCM clients with Ryan White CARE Act case management.
- Communication about an individual client with other providers is dependent upon the obtainment of written, informed consent from the client.
- A referral tracking system must be maintained.
- Annual assessment of relevant community providers with current referral and access information must be maintained.
- A mechanism to provide clients with emergency psychological or medical services must be established.

4.2.6 Monitoring and Reassessing Clients' Needs and Progress

Regular, structured meetings must be carried out between the prevention case manager and the client to assess the client's changing needs, monitor progress, and revise the Prevention Plan accordingly. In addition, HIV risk-reduction counseling must be provided at all appropriate opportunities. As mentioned previously, case managers should regularly inquire about recent sex and needle-sharing partners of seropositive clients.

If partners were potentially exposed to HIV, steps should be taken as outlined in Section 4.2.5 to inform them and encourage their participation in PCM and/or counseling and testing services. Assessment of progress in meeting the Prevention Plan objectives should be communicated to the client for review and discussion. Home visits, if appropriate, may provide a valuable opportunity for case managers to gain a

comprehensive impression of the client's social and environmental support. Individual meetings with a client must be reflected in the client's progress notes.

As individual client's progress in a PCM program and psychosocial needs are met, their needs may become less acute. Piette et al. (1992) describes the use of "high-" and "low-need" client categories with separate protocols for frequency and type of interaction to manage caseloads. Assigning individual prevention case managers a balance of new PCM clients (presumably higher need) and continuing clients (lower need) may also reduce staff burnout. Regardless of the staffing or triage system applied, monitoring ability is enhanced with a manageable caseload and adequate case records (Piette et al. 1992).

Retention of PCM clients is a concern (CDC 1997) [Purcell, DeGroff, Wolitski, Submitted for Publication]; therefore, program staff must define minimum levels of effort to reach clients for follow-up. For instance, a program should determine how many attempts - telephone calls, field visits, and so on - will be made before a client is made "inactive."

STANDARDS for Monitoring and Reassessing Clients' Needs and Progress

- Prevention case managers must meet on a regular basis with clients to monitor their changing needs and their progress in meeting HIV behavioral risk-reduction objectives. Individual meetings with a client must be reflected in the client's confidential progress notes.
- A protocol must be established defining minimum, active efforts to retain clients. That protocol should specify when clients are to be made "inactive."

4.2.7 Discharge from PCM upon Attainment and Maintenance of Risk-Reduction Goals

In establishing a Prevention Plan, the prevention case manager and client will determine the appropriate time commitment for completing the plan. This will be based on client characteristics, needs, stated Prevention Plan objectives, and PCM activities provided.

PCM is a time-limited prevention activity intended to meet achievable behavioral objectives - identified by assessment and prevention planning - through counseling, service brokerage, and monitoring. PCM is not intended to substitute for extended social services or psychological care. Once the client has accomplished the behavioral objectives set forth in the Prevention Plan, a determination must be made by the client and prevention case manager that the client is ready for discharge (for example, a client is made "inactive" or "graduates," and PCM services are terminated). At the time of discharge, the prevention case manager, together with the client, should make every effort to ensure that the client is connected to needed resources and services.

In cases when the client has achieved his or her behavioral objectives, but actively experiences relapse to unsafe behaviors and faces on-going barriers to risk reduction, continuation of PCM services may be warranted. For these clients, PCM services may emphasize continued risk-reduction counseling.

Standard for Discharge From PCM Upon Attainment and Maintenance of Risk-Reduction Goals

A protocol for client discharge must be established.

4.3 STAFF QUALIFICATIONS

In considering staff qualifications, detailing the related PCM activities, such as assessment, prevention planning, and risk-reduction counseling, and defining appropriate levels of staff training and skills for each, may be valuable. Agency managers may choose to have professionally trained staff serve as prevention case managers and carry out all PCM activities from recruitment and engagement through discharge. Other agency managers may apply a team approach to PCM, using both professionals and paraprofessionals. Paraprofessionals, under the supervision of a case manager, may be effective in assisting with functions such as recruitment, screening, and follow-up assistance to ensure coordination of care. Professionals may be more appropriate for performing the functions of PCM requiring more sophisticated skills such as assessment, prevention planning, and HIV risk-reduction counseling. If a team approach is used, an explicit, structured means for professionals, paraprofessionals, and volunteers to communicate must exist. Staff qualifications, then, should be based on the skills required to complete the various PCM functions or activities. All staff must be knowledgeable of confidentiality laws and agency confidentiality policies and procedures.

The essential components of a PCM program along with suggested minimum staff qualifications can be grouped into the following two main categories:

1. Essential Components

Client recruitment and engagement, screening, and coordination of services.

Suggested Minimum Staff Qualifications:

Knowledge of target population; cultural and linguistic competence; knowledge of HIV, AIDS, and other STDs; knowledge of available community services; and effective communication skills.

2. Essential Components

Assessment, development of a Prevention Plan, HIV risk-reduction counseling, monitoring and reassessment, on-going support and relapse prevention, graduation and discharge planning.

Suggested Minimum Staff Qualifications

A bachelor's degree or extensive experience in a human-services-related field, such as social work, psychology, nursing, counseling, or health education; skilled in case management and assessment techniques; skill in counseling; ability to develop and maintain written documentation (case notes); skill in crisis intervention; knowledgeable of HIV risk behaviors, human sexuality, substance abuse, STDs, the target population, and HIV behavior change principles and strategies; and cultural and linguistic competence.

PCM supervisors need the academic training and/or experience to adequately develop an overall PCM program, including PCM program goals and objectives, PCM protocols, and quality assurance and evaluation measures. PCM supervisors should also have management skills and experience overseeing case management staff. PCM program managers should provide an orientation to the PCM program for new workers and on-going supervision to ensure that the PCM intervention is clearly understood. On-going staff training and development is essential to build staff skills.

STANDARDS for Staff Qualifications

- Staff must be provided written job descriptions and opportunities for regular, constructive feedback. In addition, staff must be provided opportunities for regular training and development.
- Organizations must hire case managers with the appropriate training and skills to complete the PCM activities within their job description.
- All staff must be knowledgeable of confidentiality laws and agency confidentiality policies and procedures.

4.4 CASELOAD

Depending on client characteristics, needs, and PCM activities provided, an ideal caseload for a full-time prevention case manager may range from 20 to 35 clients (Rubin 1992). Caseload will vary based on the complexities of individual cases and the lengths of time clients are served. In service areas where fewer resources are available, prevention case managers may be expected to go beyond the HIV risk-reduction counseling and resource-linking roles and become providers of other direct services, if they have the appropriate skills. Such circumstances will decrease the number of clients each case manager can effectively serve.

When case managers deliver many direct services and/or when clients are younger, harder to engage in treatment, or more vulnerable to negative social forces such as poverty or homelessness, smaller caseloads are expected (Rubin 1992). Also, with smaller, more intensive caseloads, case managers may develop a more therapeutic relationship with the client. In contrast, if case managers were working primarily with low-need clients, the caseload would be expected to be higher.

4.5 COORDINATION OF PCM WITH RYAN WHITE CARE ACT CASE MANAGEMENT

The Ryan White CARE Act funds case management services for persons living with HIV or AIDS to ensure coordination and continuity of needed entitlement, medical care and treatment, housing, and other social services (See Appendix C). Eligibility for Ryan White CARE Act case management services are established at the local level by Ryan White planning councils. Because of the obvious potential for service duplication between PCM and Ryan White CARE Act case management, explicit attention to coordination of these services is essential.

Foremost, PCM is intended as an HIV primary prevention activity (to reduce the transmission and acquisition of HIV infection) and must never duplicate Ryan White CARE Act case management services. However, PCM services may be integrated into Ryan White CARE Act case management. The integration of these two services will be influenced by the eligibility requirements for Ryan White CARE Act case management in a given community, the extent of primary HIV prevention provided by Ryan White CARE Act case managers, and the range of services provided by both case management services. Together, a Ryan White Care Act case manager and a prevention case manager can determine which services are most appropriate to be provided by each. To ensure effective coordination between these two services, PCM program staff must establish explicit relationships for coordination and/or integration with Ryan White CARE Act case management providers in their jurisdiction and be knowledgeable of local Ryan White CARE Act case management eligibility criteria. Effective coordination of Ryan White case management and PCM services will benefit the client.

STANDARDS for Coordination Of PCM With Ryan White Care Act Case Management

- An explicit protocol for structuring relationships with Ryan White CARE Act case management providers must be established and should detail how to transfer and/or share clients.
- PCM must not duplicate Ryan White CARE Act case management for persons living with HIV, but PCM may be integrated into these services.

5.0 EVALUATION

5.1 QUALITY ASSURANCE

Quality assurance is essential to make certain that delivery of quality PCM services are consistent and to ensure that interventions are delivered in accordance with established standards. Project RESPECT, a study of HIV prevention counseling, emphasized quality assurance measures to maintain high performance expectations of staff and ensure consistent and comprehensive delivery of the counseling interventions (Kamb, Dillon, Fishbein, Willis, and Project RESPECT Study Group 1996).

For PCM, clear procedure and protocol manuals are necessary to ensure effective delivery of services and minimum standards of care. These manuals should address all the standards contained in this document (See Appendix B for concise list) and should be available to all staff. Written quality assurance protocols must be developed by PCM programs and should be included in procedure and protocol manuals. Client feedback should be routinely used as a factor in assessing the quality assurance of PCM services provided. Quality assurance mechanisms include the following:

Written Protocols Descriptions of specific communication-related activities, such as protocols for client engagement and follow-up, screening, risk-reduction counseling, partner notification, and so forth.

Training Training for supervisors and staff to ensure appropriate skills to complete the PCM activities within their job descriptions.

Individual Supervision Regular review of each staff member's performance, productivity level, and quality of services provided.

Chart Reviews Regular review of individual client's PCM assessment, Prevention Plan, and progress notes by the case management supervisor to ensure clear documentation and appropriate intervention.

Case Conferences and Presentations Regular presentation of cases, especially those that are complex and difficult, by case managers to peers and supervisors to discuss a client's progress and strategies for intervention.

Peer Review Regular review by a convened panel or peer group of performance and quality of services being delivered.

Client Satisfaction Surveys or Interviews Routine feedback from clients about their satisfaction with the service, their concerns, and their ideas for improvement.

Independent Program Audits Reviews and evaluations from panels of professionals from outside the agency on the quality of the program, including assurance that the program is delivering the services it is promoting. Special attention must be given to ensuring the confidentiality of clients when independent program audits are conducted.

STANDARDS for Quality Assurance

- Clear procedure and protocol manuals for the PCM program must be developed to ensure effective delivery of PCM services and minimum standards of care.
- Written quality assurance protocols must be developed and included in procedure and protocol manuals.
- Client PCM records must contain a copy of the voluntary informed consent document and the Prevention Plan showing the client's signature.

5.2 PROGRAM EVALUATION

All PCM programs should conduct process evaluation. Process evaluation provides a descriptive assessment of a program's actual operation and the level of effort taken to reach desired results (that is, what was done, to whom, and how, when, and where). Process evaluation is intended for program improvement. Process evaluation measures may be both quantitative and qualitative in nature. Possible process evaluation measures for a PCM program include the following:

- Demographic information of clients,
- Risk profiles of clients,
- Health status of clients,
- Service referrals offered and followed through,
- Number and length of PCM sessions provided,
- Client satisfaction surveys, and
- Review of quality assurance measures.

Some programs may have the capacity to conduct outcome evaluation, the assessment of the immediate or direct effects of a program on the program participants (for example, the degree to which the program increased knowledge of HIV/AIDS, perceived risk of infection, and/or decreased intent of engaging in risk behaviors related to HIV transmission). Outcome evaluation also assesses the extent to which a program attains its objectives related to intended short- and long-term change for a target population. Agencies interested in conducting outcome evaluation are encouraged to involve program evaluation experts. To date, PCM programs generally have not been required or funded to conduct outcome evaluation.

6.0 ETHICAL AND LEGAL ISSUES

All of the following issues have critical ethical and legal implications for PCM programs.

STANDARDS for Ethical and Legal Issues

Confidentiality Organizations must have well-established policies and procedures for handling and maintaining HIV-related confidential information that conform to state and federal laws. These policies and procedures must ensure that strict confidentiality is maintained for all persons who are screened, assessed, and/or participate in PCM. Most states have well-established and stringent confidentiality laws specifically related to information about HIV/AIDS.

Voluntary and Informed Consent A client's participation must always be voluntary and with the client's informed consent. Documentation of voluntary, informed consent must be maintained in the client's file. In addition, a client's informed consent is required before a prevention case manager may contact another provider serving that same client.

Cultural Competence Organizations must make every effort to uphold a high standard for cultural competence, that is, programs and services provided in a style and format respectful of the cultural norms, values, and traditions that are endorsed by community leaders and accepted by the target population. Cultural appropriateness and relevance are critical to the success of any HIV prevention activity.

Professional Ethics PCM must be governed by the same general professional ethics that govern most human service fields such as social work, counseling, and clinical psychology (For example, Hepworth, D. H. and Larsen, J. 1986).

Discharge Planning Organizations must make efforts to ensure that clients have received appropriate referrals and are adequately receiving needed services at the time of discharge (graduation).

Duty to Warn Organizations must be familiar with state and local procedures/requirements related to duty to warn other individuals at risk or in physical danger.

7.0 TECHNICAL ASSISTANCE

CDC project officers in the Division of HIV/AIDS Prevention - Intervention Research and Support, National Center for HIV, STD, and TB Prevention are available to provide technical assistance to grantees in interpreting and applying these guidance and standards.

REFERENCES

Academy for Educational Development. Handbook for HIV Prevention Community Planning. 1994.

Ajzen, I. and Fishbein, M. Understanding Attitudes and Predicting Social Behavior. Englewood Cliffs, NJ: Prentice-Hall, 1980.

Baldwin, S. and Woods, P. A. "Case Management and Needs Assessment: Some Issues of Concern for the Caring Professions." Journal of Mental Health, Vol. 3, 1994, pp. 311-322.

Centers for Disease Control and Prevention. HIV Prevention Case Management: Literature Review and Current Practice. September 1997.

GrHAAm, K. and Birchmore-Timney, C. "Case Management and Addictions Treatment." Journal of Substance-Abuse Treatment, Vol. 7, 1990, pp. 181-188.

Hepworth, D. H. and Larsen, J. Direct Social Work Practice: Theory and Skills. Chicago, Illinois: The Dorsey Press, 1986, pp. 595-601.

Kamb, M. L., Dillon, B.A., Fishbein, M., Willis, K. L., and Project RESPECT Study Group. "Quality Assurance of HIV Prevention Counseling in a Multi-Center Randomized Controlled Trial." Public Health Reports, Vol. 111, Supplement 1, 1996, pp. 99-107.

Kelly, J. A. "AIDS Prevention: Strategies That Work." AIDS Reader, July/August 1992, pp. 135-141.

Last, J. M. and Wallace, R. B, Editors. Public Health and Preventive Medicine. Thirteenth Edition. Maxcy-Rosenau-Last, Publishers, 1992, pp. 4-5.

Orwin, R. G., Sonnefeld, L. J., Garrison-Mogren, R., and Smith, N. G. "Pitfalls in Evaluating the Effectiveness of Case Management Programs for Homeless Persons: Lessons from the NIAAA Community Demonstration Project." Evaluation Review, Vol. 18, 1994, pp. 153-207.

Piette, J., Fleishman, J. A., Mor, V., and Dill, A. "A Comparison of Hospital and Community Case Management Programs for Persons with AIDS." Medical Care, Vol. 28, 1990, pp. 746-755.

Piette, J., Fleishman, J. A., Mor, V., and Thompson, B. "The Structure and Process of AIDS Case Management." Health and Social Work, Vol. 17, 1992, pp. 47-56.

PROCEED, Inc. Standards and Considerations for Establishing HIV Prevention Case Management. 1997.

Prochaska, J. O. and DiClemente, C. C. "Stages of Change in the Modification of Problem Behaviors." In M. Hersen, P. M. Miller, and R. Eisler, Editors. Progress in Behavior Modification. New York: Wadsworth Publishing Company, 1992, Vol. 28, pp. 184-218.

Purcell, D. W., DeGroff, A. S., Wolitski, R. J. "HIV Prevention Case Management: Current Practice and Future Directions." (Submitted for Publication) 1997.

Rothman, J. Guidelines for Case Management: Putting Research to Professional Use. F. E. Peacock Publishers, Inc.: Itasca, Illinois, 1992.

Rubin, A. "Is Case Management Effective for People with Serious Mental Illness? A Research Review." Health and Social Work, Vol. 17, 1992, pp. 138-150.

West, G. R. and Stark, Kathleen. "Partner Notification for HIV Prevention: A Critical Reexamination." AIDS Education and Prevention; HIV Counseling and Testing. Vol. 9, Supplement B, June 1997, pp. 68-78.

U.S. Department of Health and Human Services. Guidelines for Health Education and Risk-Reduction Activities: HIV Prevention Case Management, 1995, pp. 32-35.

U.S. Department of Health and Human Services, HIV Counseling, Testing, and Referral: Standards and Guidelines, May 1994.

ADDITIONAL INFORMATION AND READING

Academy for Educational Development. Handbook for HIV Prevention Community Planning, Washington, D.C., 1994.

Aral, Sevgi O. and Holmes, King K. "Sexually Transmitted Disease in the AIDS Era." Scientific American, Vol. 264, No. 2, February 1991, pp. 62-69.

Centers for Disease Control and Prevention. HIV Prevention Case Management: Literature Review and Current Practice. 1997.

Centers for Disease Control and Prevention. Planning and Evaluation HIV/AIDS Prevention Programs in State and Local Health Departments: A Companion to Program Announcement 300. Reissued October 1996. [Note: This document was developed specifically for state and local health department program managers.]

Centers for Disease Control and Prevention, Health Resources and Services Administration, National Institute on Drug Abuse, and Substance Abuse and Mental Health Services Administration. "HIV Prevention Bulletin: Medical Advice for Persons Who Inject Illicit Drugs." Atlanta, Georgia, and Rockville, Maryland, May 9, 1997.

Clottey, C. and Dallabetta, G. "Sexually Transmitted Diseases and Human Immunodeficiency Virus: Epidemiologic Synergy?" Infectious Disease Clinics of North America, Vol. 7, No. 4, December 1993, pp. 753-770.

Kamb, M. L., Dillon, B. A., Fishbein, M., Willis, K. L., and Project RESPECT Study Group. "Quality Assurance of HIV Prevention Counseling in a Multi-Center Randomized Controlled Trial." Public Health Reports, Vol. 111, Supplement 1, 1996, pp. 99-107.

Mejta, C. L., Bokos, P. J., Mickenberg, J. H., Maslar, M. E., and Senay, E. "Improving Substance Abuse Treatment Access and Retention Using a Case Management Approach." Journal of Drug Issues, Vol. 27, No. 2, Spring 1997, pp. 329-340.

Purcell, D. W., DeGroff, A. S., and Wolitski, R. J. "HIV Prevention Case Management: Current Practice and Future Directions." (Submitted for Publication) 1997.

Quinn, Thomas C. and Cates, Wilard, Jr. "Epidemiology of Sexually Transmitted Diseases in the 1990's." Sexually Transmitted Diseases. Edited by Thomas C. Quinn. New York: Raven Press, Ltd., 1992, pp. 1-37.

Stone, Katherine M. "Avoiding Sexually Transmitted Diseases." Obstetrics and Gynecology Clinics of North America, Vol. 17, No. 4, December 1990, pp. 789-799.

Toomey, K. E., Moran, J. S., Rafferty, M. P., and Beckett, G. A. "Epidemiological Considerations of Sexually Transmitted Diseases in Underserved Populations." Infectious Disease Clinics of North America, Vol. 7, No. 4, December 1993, pp. 739-752.

U.S. Department of Health and Human Services. HIV Counseling, Testing, and Referral Standards and Guidelines. May 1994.

U.S. Preventive Services Task Force. Guide to Clinical Preventive Services. Second Edition. Baltimore: Williams & Wilkins, 1996.

Wasserheit, J. N. "Epidemiological Synergy: Interrelationships Between Human Immunodeficiency Virus Infection and Other Sexually Transmitted Diseases." Sexually Transmitted Diseases, Vol. 19, No. 2, March-April 1992, pp. 61-77.

APPENDIX A

GLOSSARY

Client-Centered Counseling Client-centered counseling refers to counseling conducted in an interactive manner responsive to individual client needs. The focus is on developing prevention objectives and strategies with the client rather than simply providing information. An understanding of the unique circumstances of the client is required - behaviors, sexual identity, race/ethnicity, culture, knowledge, and social and economic status.

Cultural Competence In the context of PCM, services provided in a style and format respectful of the cultural norms, values, and traditions that are endorsed by community leaders and accepted by the target population.

Patient Referral In the context of notifying sex and needle-sharing partners, when the patient, that is client, notifies and refers his or her own partners for testing.

Provider Referral In the context of notifying sex and needle-sharing partners, when health professionals, usually from the health department, notify the patient's partners of their exposure.

Medical and Psychosocial In the context of PCM, "medical" and "psychosocial" encompasses the medical, psychological, and social domains of an individual.

Outcome Evaluation Outcome evaluation involves the assessment of the immediate or direct effects of a program on the program participants, for example, the degree to which the program increased knowledge of HIV/AIDS, perceived risk of infection, and/or decreased intent of engaging in risk behaviors related to HIV transmission. Outcome evaluation also assesses the extent to which a program attains its objectives related to intended short- and long-term change for a target population.

Prevention Case Management PCM is a client-centered HIV prevention activity with the fundamental goal of promoting the adoption of HIV risk-reduction behaviors by clients with multiple, complex problems and risk-reduction needs. PCM is a hybrid of HIV risk-reduction counseling and traditional case management that provides intensive, on-going, and individualized prevention counseling, support, and service brokerage.

Primary Prevention The aim of primary prevention is to reduce the incidence of disease and injury (Last and Wallace 1992). As related to HIV prevention, the aim of primary prevention is to reduce the transmission and acquisition of HIV infection through a variety of strategies, activities, interventions, and services.

Process Evaluation Process evaluation provides a descriptive assessment of a program's actual operation and the level of effort taken to reach desired results, that is, what was done, to whom, and how, when, and where.

Secondary Prevention The aim of secondary prevention is to reduce the prevalence of disease and disability (Last and Wallace 1992). As related to HIV prevention, the aim of secondary prevention is to prevent a person living with HIV from becoming ill or dying as a result of HIV, opportunistic infections, or AIDS through a variety of strategies, activities, interventions, and services.

APPENDIX B

STANDARDS FOR PCM PROGRAMS

CLIENT RECRUITMENT AND ENGAGEMENT

- Protocols for client engagement and related follow-up must be developed, such as requiring a minimum number of follow-up contacts within a specified time period.

SCREENING AND ASSESSMENT

- PCM program staff must develop screening procedures to identify persons at highest risk for acquiring or transmitting HIV and who are appropriate clients for PCM.
- All persons screened for PCM, including those who are not considered to be appropriate for PCM, must be offered counseling by the prevention case manager and referrals relevant to their needs.
- Thorough and comprehensive assessment instrument(s) must be obtained or developed to assess HIV, STD, and substance abuse risks along with related medical and psychosocial needs.
- All PCM clients must participate in a thorough client-centered assessment of their HIV, STD, and substance abuse risks and their medical and psychosocial needs.
- Case managers must provide clients a copy of a voluntary informed consent document for signature at the time of assessment. This document must assure the client of confidentiality.

DEVELOPMENT OF A CLIENT- CENTERED PREVENTION PLAN

- For each PCM client, a written Prevention Plan must be developed, with client participation, which specifically defines HIV risk-reduction behavioral objectives and strategies for change.
- For persons living with HIV and receiving antiretroviral or other drug therapies, the Prevention Plan must address issues of adherence.
- The Prevention Plan must address efforts to ensure that a PCM client is medically evaluated for STDs at regular intervals regardless of symptom status.
- For clients with substance abuse problems, the Prevention Plan must address referral to appropriate drug and/or alcohol treatment.
- Clients must sign-off on the mutually negotiated Prevention Plan to ensure their participation and commitment.
- Client files that include individual Prevention Plans must be maintained in a locked file cabinet to ensure confidentiality.

HIV RISK-REDUCTION COUNSELING

- Multiple-session HIV risk-reduction counseling aimed at meeting identified behavioral objectives must be provided to all PCM clients.
- Training and quality assurance for staff must be provided to ensure effective identification of HIV risk behaviors and appropriate application of risk-reduction strategies.
- Clients who are not aware of their HIV antibody status must receive information regarding the potential benefits of knowing their HIV serostatus.
- Clients must be provided education about the increased risk of HIV transmission associated with other STDs and about the prevention of these other STDs.

- PCM program staff must develop a protocol for assisting HIV seropositive clients in confidentially notifying partners and referring them to PCM and/or counseling and testing services. For persons receiving treatment for opportunistic infections and/or antiretroviral therapy(ies), counseling to support adherence to treatments/therapies must be provided.

COORDINATION OF SERVICES WITH ACTIVE FOLLOW-UP

- Formal and informal agreements, such as memoranda of understanding, must be established with relevant service providers to ensure availability and access to key service referrals.
- A standardized written referral process for the PCM program must be established.
- Explicit protocols for structuring relationships and communication between case managers or counselors in different organizations is required to avoid duplication of services, for example, how to transfer or co-manage PCM clients with Ryan White CARE Act case management.
- Communication about an individual client with other providers is dependent upon the obtainment of written, informed consent from the client.
- A referral tracking system must be maintained.
- Annual assessment of relevant community providers with current referral and access information must be maintained.
- A mechanism to provide clients with emergency psychological or medical services must be established.

MONITORING AND REASSESSMENT OF CLIENTS' NEEDS AND PROGRESS

- Prevention case managers must meet on a regular basis with clients to monitor their changing needs and their progress in meeting HIV behavioral risk-reduction objectives. Individual meetings with a client must be reflected in the client's confidential progress notes.
- A protocol must be established defining minimum, active efforts to retain clients. That protocol should specify when clients are to be made "inactive."

DISCHARGE FROM PCM UPON ATTAINMENT AND MAINTENANCE OF RISK-REDUCTION GOALS

- A protocol for client discharge must be established.

STAFF QUALIFICATIONS

- Staff must be provided written job descriptions and opportunities for regular, constructive feedback. In addition, staff must be provided opportunities for regular training and development.
- Organizations must hire case managers with the appropriate training and skills to complete the PCM activities within their job description.
- All staff must be knowledgeable of confidentiality laws and agency confidentiality policies and procedures.

COORDINATION OF PCM WITH RYAN WHITE CARE ACT CASE MANAGEMENT

- An explicit protocol for structuring relationships with Ryan White CARE Act case management providers must be established and should detail how to transfer and/or share clients.
- PCM must not duplicate Ryan White CARE Act case management for persons living with HIV, but PCM may be integrated into these services.

QUALITY ASSURANCE

- Clear procedure and protocol manuals for the PCM program must be developed to ensure effective delivery of PCM services and minimum standards of care.
- Written quality assurance protocols must be developed and included in procedure and protocol manuals.
- Client PCM records must contain a copy of the voluntary informed consent document and the Prevention Plan showing the client's signature.

ETHICAL AND LEGAL ISSUES

Confidentiality

- Organizations must have well-established policies and procedures for handling and maintaining HIV-related confidential information that conform to state and federal laws.
- These policies and procedures must ensure that strict confidentiality is maintained for all persons who are screened, assessed, and/or participate in PCM.
- Most states have well-established and stringent confidentiality laws specifically related to information about HIV/AIDS.

Voluntary and Informed Consent

- A client's participation must always be voluntary and with the client's informed consent.
- Documentation of voluntary, informed consent must be maintained in the client's file.
- In addition, a client's informed consent is required before a prevention case manager may contact another provider serving that same client.

Cultural Competence

- Organizations must make every effort to uphold a high standard for cultural competence, that is, programs and services provided in a style and format respectful of the cultural norms, values, and traditions that are endorsed by community leaders and accepted by the target population.
- Cultural appropriateness and relevance are critical to the success of any HIV prevention activity.

Professional Ethics

- PCM must be governed by the same general professional ethics that govern most human service fields such as social work, counseling, and clinical psychology.

Discharge Planning

- Organizations must make efforts to ensure that clients have received appropriate referrals and are adequately receiving needed services at the time of discharge (graduation).

Duty to Warn

- Organizations must be familiar with state and local procedures/requirements related to duty to warn other individuals at risk or in physical danger.

APPENDIX C: RYAN WHITE CARE ACT PROGRAMS

The Health Resources and Services Administration (HRSA) is one of eight agencies in the U.S. Department of Health and Human Services. Within HRSA four bureaus provide funding for the delivery of HIV/AIDS care, services (including case management), and training - the Bureau of Health Resources Development (BHRD), Bureau of Primary Health Care (BPHC), Bureau of Maternal and Child Health (MCHB), and Bureau of Health Professions (BHPr).

Each of the four HRSA bureaus conducts programs to benefit low-income, uninsured, and underinsured individuals and families affected by HIV/AIDS through the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. HRSA's AIDS Program Office (1) provides direction; (2) coordinates HIV/AIDS health care-related activities across the bureaus; and (3) works with other federal and state agencies, providers, and constituent groups to identify emerging issues and needs and to facilitate integrated, client-oriented HIV/AIDS services.

Signed into law on August 18, 1990, the Ryan White CARE Act was named after the Indiana teenager, Ryan White, who became an active public educator on HIV/AIDS after he contracted the disease. He died that same year. The act, which was amended in May 1996, provides assistance to improve the quality and availability of care for people with HIV/AIDS and their families.

HRSA administers HIV/AIDS programs under four titles and Part F of the act, which are described as follows:

Title I - HIV Emergency Relief Grant Program for Eligible Metropolitan Areas Title I is administered by BHRD's Division of HIV Services. This program provides formula and supplemental grants to Eligible Metropolitan Areas (EMAs) that are disproportionately affected by the HIV epidemic. For an area to be eligible, it must have a population of 500,000 or more and have reported more than 2,0**00 AIDS cases in the preceding 5 years.**

Title II - HIV Care Grants to States Title II is also administered by BHRD's Division of HIV Services and provides formula grants to states, U.S. territories, the District of Columbia, and Puerto Rico to provide health care and support services for people with HIV/AIDS. Grants are awarded based on (1) the estimated number of living AIDS cases in the state or territory; and (2) the estimated number of living AIDS cases within the state or territory but outside of Title I EMAs (that is, outside an area with 500,000+ population and 2,000+ AIDS cases/previous 5 years). Additionally, grantees must provide therapeutics to treat HIV/AIDS under the AIDS Drug Assistance Program (ADAP).

Title III(b) - HIV Early Intervention Services BPHC's Division of Programs for Special Populations administers Title III(b) of the act through the Early Intervention Services Program. This program supports outpatient HIV early intervention services for low-income, medically underserved people in existing primary care systems. Medical, educational, and psychosocial services are designed to prevent the further spread of HIV/AIDS, delay the onset of illness, facilitate access to services, and provide psychosocial support to people with HIV/AIDS.

Title IV - Coordinated HIV Services and Access to Research for Children, Youth, Women, and Families Title IV is a special grant program directed by MCHB to coordinate HIV services and access to research for children, youth, women, and families in a comprehensive, community-based, family-centered system of care.

Part F - Special Projects of National Significance Program BHRD's Office of Science and Epidemiology administers the Special Projects of National Significance (SPNS) Program to support the development of innovative models of HIV/AIDS care. These models are designed to address special care needs of individuals with HIV/AIDS in minority and hard-to-reach populations. Additionally, they are expected to be replicable and have a strong evaluation component. Integrated service delivery models were funded in Fiscal Year 1996 to create formal linkages to integrate health and support services.

Part F - AIDS Education and Training Centers Fifteen AIDS Education and Training Centers (AETCs) have been established under BHPr. The AETCs are a national network of centers that conduct targeted, multidisciplinary education and training programs for health care providers in designated geographic areas. The AETCs increase the number of health care providers who are educated and motivated to counsel, diagnose, treat, and manage care for individuals with HIV/AIDS and to help prevent high risk behaviors that may lead to further HIV transmission.

Part F - AIDS Dental Reimbursement Program BHPr also administers the AIDS Dental Reimbursement Program. This grant program assists accredited dental schools and post-doctoral dental programs with uncompensated costs incurred in providing oral health treatment to HIV-positive patients.

For additional information on the Ryan White CARE Act, contact

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Adapted, with permission, from HRSA's AIDS Program Office, "HRSA Fact Sheet," March 1997.

Partner Counseling and Referral Services (PCRS)

PCRS provides a systematic approach to notifying sex and needle-sharing partners of HIV-infected persons of their possible exposure to HIV so they can avoid infection or, if already infected, can prevent transmission to others. PCRS helps partners gain earlier access to individualized counseling, HIV testing, medical evaluation, treatment, and other prevention services.

Counseling and testing refers to the voluntary process of HIV testing accompanied by client-centered, interactive information-sharing in which an individual is made aware of the basic information about HIV/AIDS, testing procedures, and how to prevent the transmission and acquisition of HIV infection. In the best of situations, the individual also receives tailored support on how to adapt this information to his or her life.

Referral is the process by which individuals with high-risk behaviors and those infected with HIV are guided towards prevention, psychosocial, and medical resources needed to meet their primary and secondary HIV prevention needs.

Voluntary partner notification is the voluntary process by which sex and needle-sharing partners of a person who is either HIV positive or at high-risk for HIV are located, informed of their possible risk, and encouraged to seek counseling and testing for themselves.

The **standards** for PCRS are included in the following document, the CDC **Guidance** for PCRS.

HIV Partner Counseling, Testing and Referral Services Standards and Guidelines

US Department of Health & Human Services
Public Health Service
Centers for Disease Control and Prevention
December 1998

Preface

This guidance uses new terminology to label the process of reaching and serving sex and needle-sharing partners. As opposed to *contact tracing and partner notification*, the term *partner counseling and referral services* (PCRS) is used in this document because it better reflects the type and range of public health services that are recommended for sex and needle-sharing partners. These services are vital to any community' s HIV prevention efforts. This guidance should assist in developing programs, planning services, or prioritizing resource allocation for PCRS, and state and local programs supported with CDC funds should adapt it to meet their local policies, needs, and circumstances.

The principles listed on the following pages constitute the basis for PCRS and are applied to issues discussed throughout this document. Principles 1-8 apply to partner counseling and referral services associated with partner services for all sexually transmitted diseases, including HIV. Principles 9-13 apply to partner counseling and referral services associated with HIV in particular.

1. **Voluntary.** PCRS is voluntary on the part of the infected person and his or her partners.
2. **Confidential.** Every part of PCRS is confidential.
3. **Science-Based.** PCRS activities are science-based and require knowledge, skill, and training.
4. **Culturally Appropriate.** PCRS is to be delivered in a nonjudgmental, culturally appropriate, and sensitive manner.
5. **A Component of a Comprehensive Prevention System.** PCRS is one of a number of public health strategies to control and prevent the spread of HIV and STDs. Other strategies include access to clinical services, outreach to and targeted screenings of at-risk populations, behavioral interventions, and educational programs.
6. **Diverse Referral Approaches.** PCRS may be delivered through two basic approaches: provider referral, whereby the PCRS provider locates and informs sex or needle-sharing partners of their exposure, and client referral, whereby the infected person takes responsibility for informing his or her partners. Sometimes a combination of these approaches is used.
7. **Support Services and Referral.** PCRS is delivered in a continuum of care that includes the capacity to refer sex and needle-sharing partners to HIV counseling, testing, and treatment, as well as other services, e.g., STD treatment, family planning, violence prevention, drug treatment, social support, housing.
8. **Analysis and Use of PCRS Data.** PCRS program managers should collect data on services provided and use the data for evaluating and improving program efficiency, effectiveness, and quality.
9. C**ounseling and Support for Those Who Choose To Notify Their Own Partners**. Counseling and support for those who choose to notify their own partners is an essential element of PCRS. Such efforts can assist in ultimately reaching more partners and minimizing unintended consequences of notification. Assistance to clients in deciding if, how, to whom, where, and when to disclose their infection can help them avoid stigmatization, discrimination, and other potential

negative effects. Working with a client to think through what it means to notify a partner and creating a specific plan to ensure he or she successfully accomplishes the notification is a vital role of the provider.

10. **Client-Centered Counseling.** Providing client-centered counseling for HIV-infected individuals and their partners can reduce behavioral risks for acquiring or transmitting HIV infection. In addition, client-centered counseling will help the provider understand the readiness of the client to notify partners. This will allow the provider to offer services to assist the client in successfully notifying partners without adverse consequence.
11. **Increased Importance as New Technologies Emerge.** As new technologies emerge, such as rapid diagnostic tests, vaccines, behavioral interventions, and even more effective therapies, PCRS will become an increasingly important prevention tool.
12. **Ongoing Access to PCRS for HIV-Infected Individuals and Partners.** PCRS should not be a one-time service. It should be offered as soon as an HIV-infected individual learns his or her serostatus and made available throughout that person' s counseling and treatment. If new partners are exposed in the future, PCRS should be made available again. HIV-infected individuals should have the ability to access PCRS whenever needed.
13. **Assistance in Accessing Medical Evaluation and Treatment To Prolong Life.** Sex and needle-sharing partners might already be HIV-infected but be unaware of or deny their risks. They can be assisted through PCRS in learning their status, and in obtaining earlier medical evaluation and treatment for HIV disease and opportunistic infections. PCRS provides an opportunity for HIV primary prevention interventions for those partners not infected with HIV and an opportunity for secondary prevention for those partners living with HIV.

How to use this document

The standards and guidance in this document describe the core elements that are essential for successful PCRS programs at publicly funded sites. Even though HIV and STD programs share many common goals, policies, and activities, PCRS is designed specifically for HIV prevention programs. It is not intended to replace or modify CDC guidance for partner notification for other STDs.

The two levels of recommendations in this document are **Standards** and **Guidance:**

Standards. Specific standards are provided in several sections in boxed text and are intended to be applied consistently. **Standards must be followed** by CDC grantees in virtually all cases where CDC funds are used to support services.

Guidance. The main text of this document provides overall guidance for PCRS programs. **This guidance *should* be followed** in most cases, but can be tailored to fit the individuals and affected communities being served as well as the program needs. Providers are urged to follow this guidance but have flexibility to modify or adapt based on state or local needs, policies, or

1.1 How HIV PCRS Has Evolved

Once known as "contact tracing," outreach activities for finding, diagnosing, and treating partners of persons infected with sexually transmitted diseases (STDs) have long been used by public health workers as a prevention activity. In the 1930s, U.S. Surgeon General Thomas Parran advocated the use of contact tracing to help "prevent new chains of [syphilis] infection" (Parran, 1937). Contact tracing was later expanded to include partners of persons infected with gonorrhea and other STDs, including the human immunodeficiency virus (HIV), and came to be known in the 1980s as "partner notification" (West and Stark, 1997).

In the 1980s, when public health workers were first being confronted with the rapid spread of HIV, the virus that causes acquired immunodeficiency syndrome (AIDS), informing persons of their possible exposure to HIV and offering counseling, testing, and referral services were already recognized as an

important disease prevention effort that could help stem the tide of HIV infection. As HIV prevention activities have evolved, so has the terminology for informing the HIV-infected person's sex and needle-sharing partners of their possible exposure to the virus. Today, the term *HIV partner counseling and referral services (PCRS)* more accurately reflects the range of services available to HIV-infected persons, their partners, and affected communities through this public health activity.

Of necessity, PCRS for HIV differs from partner services for other STDs because the "epidemiological, biological, and clinical characteristics of HIV are different" (West and Stark, 1997). Despite recent advances in treatment, we do not yet have a cure for AIDS, so HIV remains a lifelong issue for those infected. Furthermore, because society frequently stigmatizes and sometimes discriminates against HIV-infected persons and their families and friends, the affected communities may be concerned about the potential negative impact of PCRS. HIV prevention programs need affected communities to be involved in and understand PCRS for the overall prevention efforts to be accepted and effective.

Federal and state legislative mandates in the 1990s have underscored the importance of notifying sex and needle-sharing partners of their possible exposure to HIV. Recent examples include the federal requirement to notify spouses of HIV-infected persons (Public Law 104-146, Section 8[a] of the Ryan White CARE Reauthorization Act of 1996) and state legislation to require health departments to offer HIV partner notification services to newly reported HIV-infected persons (National Council of State Legislators, 1998). Legal and ethical concepts such as the rights of individuals to know their risk of infection, to learn their HIV status anonymously or confidentially, and to be protected against discrimination if HIV-infected, will continue to drive public health policies and legislative action on HIV PCRS (West and Stark, 1997). Public health policies and legislative actions related to the above concepts will determine, at least in part, how PCRS is conducted.

1.2 What Are the Goals of PCRS?

PCRS is a prevention activity with the following goals:

- Providing services to HIV-infected persons and their sex and needle-sharing partners so they can avoid infection or, if already infected, can prevent transmission to others.
- Helping partners gain earlier access to individualized counseling, HIV testing medical evaluation, treatment, and other prevention services.

Through PCRS, persons - many of whom are unsuspecting of their risk - are informed of their exposure or possible exposure to HIV. Notified partners can choose whether to be tested, and if not tested or if found to be uninfected, can receive counseling about practicing safer behaviors to avoid future exposure to HIV. If, however, they are found to be infected, they can seek early medical treatment and practice behaviors that help prevent transmission of HIV to others and reduce the risk of becoming infected with other STDs.

PCRS can be instrumental in identifying sexual and drug-injecting networks at high risk for transmission of HIV or other sexually transmitted diseases (Fenton and Peterman, 1997; West and Stark, 1997). These networks are made up of individuals who share social relationships involving sex or drug use. Such networks can be identified and described at least partly through information obtained by PCRS activities (West and Stark, 1997). Future prevention interventions can then be more effectively directed, and the HIV risks within the network(s) potentially reduced. Network research, combined with new methods of virus typing and identification of recently infected persons (Janssen, *et al.*, 1998), will contribute to a greater understanding of HIV transmission (Fenton and Peterman, 1997).

1.3 Is PCRS Cost-effective?

Some have raised concerns about the high potential cost of PCRS and have questioned on these grounds whether or not it should be supported. In fact, although the relative investment per person reached might be greater than other public health activities, PCRS is likely to be highly cost-effective. A simple threshold analysis illustrates the probable cost-effectiveness of PCRS to society. Assuming an estimated current $154,402 lifetime cost in the United States of a person acquiring HIV infection and eventually dying from HIV-related illness (Holtgrave and Pinkerton, 1997) and a conservatively estimated average $3,205 cost of PCRS to reach one infected person (Toomey *et al.*, 1998), PCRS must prevent 1 infection out of every 51 HIV-infected partners reached through PCRS to be cost-effective. As PCRS links HIV-infected partners to client-centered counseling and other interventions proven or likely to be effective, this appears to be a threshold relatively easy to achieve by programs. Greater effectiveness, such as preventing only 2-3 infections for every 51 HIV-infected partners reached through PCRS, would convey substantial cost savings to society.

1.4 Who Benefits from PCRS?

Clearly, three distinct beneficiaries of PCRS are (1) persons with HIV infection; (2) their spouses and other sex and/or needle-sharing partners; and (3) affected communities (Fenton and Peterman, 1997). Through a client-centered approach, HIV-infected persons can receive counseling about their risk behavior and be offered a range of choices and support in informing their partners of the possibilities of exposure to HIV (CDC, 1994). Studies have shown that a client-centered counseling approach can result in behavior change, thereby decreasing the likelihood of HIV transmission to others (Kamb *et al.*, 1998 and Fenton and Peterman, 1997). HIV-infected persons can also benefit from referrals to other social and medical services, such as couples counseling, prevention case management, and antiretroviral therapy.

For the partners of HIV-infected persons, one basic benefit comes from being informed that they are at risk. This will be particularly helpful information for those who do not even suspect that they might have been exposed. Once informed, the partner can decide to access available HIV prevention counseling and testing services. If not infected with HIV, partners can be assisted in changing their risk behavior, thus reducing the likelihood of acquiring the virus. Or, if already HIV-infected, the partner' s prognosis can be improved through earlier diagnosis and treatment.

The role of PCRS, earlier diagnosis, and prevention and treatment services might have prevention benefits at the community level in reducing future rates of HIV transmission. Evidence is accumulating that antiretroviral therapy reduces the amount of HIV in genital secretions and fluids and thus might reduce the infectivity of HIV (Gupta P, *et al.*, 1997; Vernazza PL, *et al.*, 1997; Vernazza PL, *et al*., 1997; Musicco M, *et al*., 1994). However, concern may be well justified that some might misinterpret antiretroviral therapy as a cure for HIV and thus be less concerned about adopting safe behaviors or exposing others (Kalichman SC, *et al*., 1998; Kelly JA, *et al.,* 1998; Remien RH, *et al*., 1998; Remien RH, *et al*., 1998). Efforts to link HIV-infected persons to treatment must also continue to emphasize safe behavior during the course of treatment. Effective PCRS also can improve disease surveillance, identify social sexual networks at high risk that can then be targeted for prevention (Fenton and Peterman, 1997), and potentially assist a comprehensive program in lowering the transmission rate of HIV. In addition, PCRS can benefit service providers in the community by increasing their access to individuals in need of their services, especially people who would not come to them on their own.

1.5 What Activities Are Involved in PCRS?

PCRS should be introduced at the point an individual seeks HIV prevention counseling and testing. A brief overview of the activities associated with PCRS is included in this section, but more detailed discussions are provided throughout the remainder of this document.

- **Person Seeks HIV Prevention Counseling and Testing**. PCRS begins when persons seek, either through private care providers or publicly funded programs, HIV prevention counseling and testing. As they enter services, they should be assisted first, ideally through client-centered counseling techniques, in -
    1. assessing their risks of acquiring or transmitting HIV, and
    2. negotiating a realistic and incremental plan for reducing risk.

  During the initial counseling and testing session, the provider should also explain (1) how HIV testing will be conducted if the client does choose to be tested, and (2) all the available options for PCRS. The provider must assist clients in understanding their responsibility, if their HIV test results are positive, for ensuring that their partners are informed of their possible exposure, and referring those partners to HIV prevention counseling, testing, and other support services (CDC, 1994).
- **Client Tests Positive and Chooses To Participate in PCRS**. Once a client' s test results are confirmed positive, that person should be provided the earliest appropriate opportunity to receive partner counseling and referral services. Reactions to learning one is infected with HIV vary, and personal circumstances differ among individuals. PCRS providers need to recognize and accommodate those clients who need other issues resolved before being ready to participate in PCRS. This might mean, for some individuals, scheduling a follow-up appointment to discuss PCRS issues more thoroughly.
- **PCRS Provider and Client Together Formulate a Plan and Set Priorities.** The PCRS provider (who might not be the counseling and testing provider) counsels the client on if, how, and when specific partners should be informed of their risk of exposure. The provider should present partner referral options (Section 3.2). Then, the client and PCRS provider together can develop a plan for reaching partners that uses one or more of the referral options. The plan should be one that will result in each partner being (1) informed of possible exposure to HIV; (2) provided with accurate information about HIV transmission and prevention; (3) informed of benefits of knowing one' s serostatus; (4) assisted in accessing counseling, testing, and other support services; and (5) cautioned about the possible negative consequences of revealing their own or others' serostatus to anyone else. As the individualized plan is developed, the PCRS provider and client prioritize which partners should be reached first (Section 3.0 provides a discussion of how priorities are set).
- **HIV-Infected Client Voluntarily Discloses Information About Partners.** The HIV-infected client is encouraged to voluntarily and confidentially disclose the identifying, locating, and exposure information for each sex or needle-sharing partner that the PCRS provider or the client will attempt to inform.
- **Client and/or Provider Informs Each Partner of Possible Exposure to HIV.** The client and/or the PCRS provider inform each sex or needle-sharing partner who can be located of his or her possible exposure to HIV. Ideally, the partner is always informed confidentially face-to-face, but this cannot necessarily be ensured when the client chooses to inform the partner without the provider's assistance.
- **Client and/or Provider Assists Partner in Accessing Counseling, Testing, and other Support Services.** At the core of PCRS is referring the now-informed partner to counseling, testing, and needed social and medical services. If on-the-spot counseling and/or testing for HIV and other STDs is not practical or not desired at this time, each partner should receive, immediately upon being informed of possible exposure to HIV, a specific referral for obtaining client-centered counseling and testing. Some partners will also need immediate referrals for medical evaluation, substance abuse treatment, mental health, or other support services to enhance or sustain risk-reducing behaviors.

How each PCRS activity is conducted might have a direct impact on how communities perceive the value of such efforts to themselves and to public health. Quality assurance for services provided, routine staff and program evaluations, and network analysis are, therefore, necessary components of PCRS. For example, ensuring that strict confidentiality is maintained for all persons involved in PCRS will encourage community support and involvement. (See Sections 4.3, 4.5, and 6.2)

2.0 AVAILABILITY OF PCRS

2.1 Making Services Available to All HIV-infected Persons

People can learn that they are HIV-infected through a variety of sources, including confidential and anonymous testing sites, private care physicians, or home collection kits. However, regardless of where and how persons have been tested, PCRS must be made easily accessible to all HIV-infected persons. For example, an HIV-infected person who has been tested by a private provider might seek services from a CDC-funded provider. Although verified evidence of HIV infection should always be presented to the PCRS provider before partners are contacted, PCRS must be made available to the HIV-infected person.

The client who has just been informed of being HIV-infected will, of course, need to have PCRS offered at the earliest appropriate time, but the PCRS provider will encounter many others to whom services should be offered. For example, those persons could include a previously identified HIV-infected -

- client who in the past was not offered PCRS;
- sex or needle-sharing partner who the PCRS provider learns is continuing to have unprotected sex and who has partners other than the original HIV-infected client;
- client who now has new sex or needle-sharing partners;
- client who is now seeking additional STD or family planning services or substance abuse treatment; or
- client who in the past refused or only partially participated in PCRS but has now decided to participate fully.

Health department HIV prevention program staff should ensure that health care and prevention providers in the community and HIV-infected persons in the area are aware that PCRS is available at publicly funded sites and are aware of how to access those services. Furthermore, health departments can expand access to PCRS by developing agreements with private providers. These agreements could specify that the private providers will deliver PCRS to their HIV-infected clients. In such situations, these providers should be given relevant information, training, and support to successfully deliver the services.

STANDARD: All CDC-funded HIV prevention counseling and testing sites, both confidential and anonymous, must make PCRS available to all HIV-infected persons.

2.1.1 Services for Those Persons Tested Anonymously

Opportunities to access PCRS must be provided to HIV-infected clients who have been tested anonymously and choose to remain anonymous. Program experience has indicated that PCRS can be conducted in an anonymous setting (Hoffman, *et al.*, 1995). CDC requires that, unless prohibited by state law or regulation, grantees must provide reasonable opportunities for anonymous testing. Clients who test HIV-positive in anonymous settings must be counseled on how to enter a confidential system and be strongly encouraged to do so. This will assist them in receiving medical care and other services, including PCRS.

Recent reports show that persons who enter anonymous HIV testing programs do so earlier in their HIV infection and are more likely to begin medical care while still comparatively well (Bindman *et al*., 1998; Nakashima *et al*., 1998). CDC currently recommends that persons initially testing positive for HIV in an anonymous setting be counseled and informed about how to enter a confidential medical care system.

STANDARD: CDC-funded programs must provide access to PCRS for persons testing anonymously without requiring that the infected client disclose his or her identity.

2.1.2 Inability to Pay

CDC-funded PCRS programs must provide access to PCRS regardless of clients' or partners' ability to pay (CDC, 1993).

2.2 Accommodating Requests from Other Health Jurisdictions

PCRS providers might sometimes be asked to contact the partner of an HIV-infected person residing in another health jurisdiction. Such contacts in other jurisdictions are the role of the state health department. For example, a PCRS provider might request that the staff in a neighboring state health department assist in locating and informing a previous partner or former spouse of an HIV-infected client. A reasonable effort must be made to accommodate that request if it complies with state and local regulations and policies, and confidentiality is maintained.

STANDARD: Requests for PCRS from other health jurisdictions must be accommodated whenever practical.

3.0 DECIDING ON A PCRS PLAN AND SETTING PRIORITIES

3.1 Encouraging Client Participation

3.1.1 Fully Informing and Reassuring Clients

The PCRS provider should explain the purpose and process of PCRS before PCRS activities can begin. The HIV-infected person serves as the "gate-keeper" to his or her partners. Program experience indicates that once a person understands the benefits both to themselves and their partners, they willingly participate in PCRS. Therefore, ensuring that the HIV-infected person fully understands the PCRS process and its benefits is important.

Providers should create an environment that is private, confidential, and comfortable enough so that clients are encouraged to participate in PCRS without feeling fearful or coerced. Reminders of the voluntary nature of PCRS and explanations of how privacy will be maintained for clients and partners alike will be necessary before some individuals feel secure enough to participate.

Each interaction a counseling and testing or health care provider has with an HIV-infected client is a potential opportunity to discuss the importance of informing that person' s sex or needle-sharing partners of their possible exposure to HIV. Prevention counseling, prevention case management, and medical follow-up sessions while clients are in treatment, all provide opportunities to stress the importance of getting partners involved in PCRS. Community-level interventions provide other opportunities to reach out to partners.

STANDARD: PCRS providers must ensure that clients are aware that all information disclosed by them will be kept strictly confidential and that participation is always voluntary.

3.1.2 Developing an Atmosphere of Trust

The success of the PCRS process hinges on the trust and cooperation of the persons infected with HIV and their partners. How well the provider fosters an atmosphere of trust, respect, and rapport with the HIV-infected individual will have a significant impact on PCRS. Client-centered counseling techniques (CDC, 1994) are highly recommended for developing this relationship, not only with original clients but also with their partners. The ability to develop trust and rapport will also enhance the PCRS provider' s effectiveness when working in the community.

STANDARD: To foster an atmosphere of trust, PCRS providers must treat all HIVB-infected clients and their partners with respect.

3.1.3 Introducing PCRS

During the first visit, the health care provider, using a client-centered approach (CDC, 1994), should begin discussions with the client on the risks to his or her partners. This visit would typically be for HIV counseling and testing. When clients choose to be tested and the results are positive, then the provider must offer, at the earliest appropriate opportunity, to assist in formulating an individualized PCRS plan. That plan is always based on the personal circumstances of the HIV-infected client and each of his or her partners.

When the provider demonstrates genuine concern for the overall well being of clients and their partners during discussions about PCRS, the provider encourages greater client participation. Clients' reactions vary significantly to learning that their HIV test results are positive; therefore, the provider must gauge the appropriate point at which to initiate the discussion about the PCRS plan. In fact, other critical issues might need to be resolved first. For example, the client might express suicidal ideation or a fear of a violent reaction from a partner. Because potentially violent situations might be encountered, collaboration between the PCRS program and the appropriate state or local violence prevention programs is important. Such collaboration will help in developing plans and protocols for such situations and provide opportunities for the PCRS provider to learn about relevant services.

STANDARD: Persons entering CDC-funded prevention counseling and testing programs must be counseled at the earliest opportunity about PCRS and options for informing sex and needle-sharing partners of possible exposure to HIV.

3.2 Formulating a PCRS Plan

HIV prevention programs use two basic approaches for reaching partners (West and Stark, 1997). In this document, the term ***client referral*** is used when HIV-infected individuals choose to inform their partners themselves and refer those partners to counseling and testing (see Section 3.2.1). (NOTE: The terms ***patient referral*** and ***self-referral*** are sometimes used instead of ***client referral***.) The term ***provider referral*** is used in this document when the PCRS provider, with the consent of the HIV-infected client, takes the responsibility for contacting the partners and referring them to counseling, testing, and other support services (see Section 3.2.2).

Sometimes a combination of the two approaches is used. With the ***dual-referral*** approach, the HIV-infected client informs the partner of his/her serostatus in the presence of the PCRS provider. By having a

professional counselor present, this approach supports the client and reduces other potential risks. In such situations the PCRS provider must not reveal the client' s serostatus to the partners without prior informed consent. With the ***contract-referral*** approach, the PCRS provider does the informing only if the client does not notify the partner within a negotiated time period (see Section 3.2.3).

The PCRS provider should explain to clients all available options for reaching their partners, including the advantages and disadvantages of each approach. Then, together they can formulate a plan that can result in each partner being confidentially informed and encouraged to access counseling and testing or other social or medical services. Some HIV-infected individuals will be reluctant to participate in PCRS. Client-centered counseling techniques and reassurances of confidentiality can encourage better participation. Resolving problems through role-playing, for example, might help clients overcome barriers to participating in PCRS and help them better prepare for their part in those activities. No matter which approach is chosen, the PCRS provider should ensure the partners are actually informed of the exposure.

STANDARD: The PCRS provider must explain to the HIV-infected client the options for serving partners and then assist that client in deciding on the best plan for reaching each partner confidentially and referring him or her to counseling, testing, and other support services.

3.2.1 Taking a Closer Look at Client Referral

When HIV-infected clients choose to inform their partners themselves, they usually need some assistance to succeed. Although the majority of clients do not experience negative consequences when notifying partners, the PCRS provider can help the client minimize any potentially negative consequences. The provider should, therefore, be prepared to assess the situation and ability of the HIV-infected client to make successful notification and referrals. Based on this information, clients might need to be coached on:

1. the best ways to inform each partner;
2. how to deal with the psychological and social impact of disclosing one' s HIV status to others;
3. how to respond to a partner' s reactions, including the possibility of personal violence directed toward the client or others; and
4. how and where each partner can access HIV prevention counseling and testing.

Despite the provider' s coaching, however, the client' s lack of counseling skills and experience might result in unsuccessful or ineffective PCRS. Another disadvantage of the client-referral approach is that the client might unintentionally convey incorrect information about HIV transmission, available support services, confidentiality protections, or other issues. The client also forfeits anonymity to partners, increasing the potential for disclosure of serostatus to third parties, subsequent discrimination, or partner repercussion. The findings of Landis *et al.* (1992) clearly indicate that fewer partners are actually informed of their possible exposure to HIV when the client-referral approach is used. However, because PCRS is a voluntary process, clients should be able to choose this approach. The PCRS program needs reasonable systems for monitoring whether partners are actually reached (see "Contract Referral" in Section 3.2.3). Also, more support to the client in notifying their partners will enhance the effectiveness of notifying partners.

For anonymous test sites, the client-referral approach poses a slightly different problem because some clients might be less likely to give the provider information about partners. Under these circumstances the provider will be less likely to determine whether PCRS has been successful. Although PCRS can be provided to anonymous clients, CDC currently recommends providers encourage the client to voluntarily enter a confidential setting for PCRS and additional medical follow-up. Here again, an appropriately detailed discussion with anonymous clients of how confidentiality will be maintained for themselves and

their partners can ease the transition of anonymous clients to a confidential setting. That transition will also be eased if clients are not required to take another HIV test. If the anonymous and confidential test sites are at separate facilities, reciprocal agreements between the two might be necessary so that the client' s confirmed positive test result can easily be transferred to the confidential setting.

At confidential test sites, PCRS providers should make every reasonable effort to follow up with each HIV-infected client to assess how well he or she has progressed with PCRS. Whenever feasible, careful and confidential monitoring of which of the client' s partners actually do access counseling and testing services can greatly enhance quality assurance and program evaluation. This also will help ensure that partners have actually been reached.

Despite its drawbacks, client referral is the approach frequently chosen, and it can have some advantages. Because the client is usually more familiar with the identity and location of the partner, this approach can allow some partners to be referred for counseling and testing more promptly. Also, some clients choose this approach because they feel the best way to preserve a current relationship is by informing the partners themselves rather than having a third party - the provider - do it. Finally, when client referral is conducted successfully, fewer staff is used and fewer resources are consumed than with the provider-referral approach, so the financial burden for HIV prevention programs is reduced.

3.2.2 Taking a Closer Look at Provider Referral

When the client chooses provider referral, the provider will also need to assess the situation regarding each partner, including the best ways to inform them, how to locate and contact them, suggestions on how to approach them, how to predict the psychosocial impact of their learning their HIV serostatus, and how to respond to partners' reactions. Research indicates that provider referral is more effective in serving partners than client referral (Landis *et al.*, 1992). The following are some of the advantages of using the provider-referral approach:

1. The PCRS provider is able to readily verify that partners have been confidentially informed and have received client-centered counseling and testing services.
2. The PCRS provider can better ensure the HIV-infected client' s anonymity since no information about the client is disclosed to his or her partners.
3. A well-trained PCRS provider is better able to defuse the partner' s potential anger and blame reactions as well as accurately and more comprehensively respond to the partner' s questions and concerns.
4. Provider referral better facilitates learning about sexual and drug-injection networks, thus potentially enhancing overall HIV prevention efforts in affected communities.
5. In many cases, the PCRS provider can deliver on-site HIV testing to the partner.

Among the disadvantages of the provider-referral approach is the fact that PCRS providers are not always able to readily locate and identify the partners. Because the provider is less familiar with how to reach the partners, actually locating them to discuss their possible exposure to HIV can be more difficult. The provider-referral approach also entails substantial financial costs and causes some ethical concerns among leaders of affected communities (Fenton and Peterman, 1997; West and Stark, 1997). For example, Fenton and Peterman (1997) found that financial costs for provider referral are between $33 and $373 per partner notified and between $810 and $3,205 per infected partner notified. This program expense, however, is greatly offset in the long run because PCRS frequently reaches persons who do not suspect they have been exposed to HIV and is likely cost-effective (see Section 1.3). Once informed, they can access prevention counseling and testing, and if HIV-infected, they can enter treatment earlier. It is important to note that some infected people who choose provider referral might still notify some partners about their serostatus and will thus need relevant counseling.

3.2.3 Taking a Closer Look at Combined Referral Approaches

Two variations on provider and client referral are the dual- and contract-referral approaches. Potentially, combinations of these approaches can enhance the advantages of both approaches for the client while reducing the disadvantages.

Dual Referral. Some HIV-infected clients feel that they and their partners would be best served by having both the client and the provider present when the partner is informed. The dual-referral approach can work well for these clients. The dual approach allows the client to receive direct support in the notification process. The PCRS provider is available to render immediate counseling, answer questions, address concerns, provide referrals to other services, and in some cases potentially minimize partner repercussions. Being present also enables the provider to know which partners have in fact been served, and to some extent, learn about sexual and drug-injecting networks. Whether the client or provider will take the lead in informing the partner should be worked out in advance of the notification.

The provider still needs to coach and support the client as with the client-referral approach. The provider and the HIV-infected client need to consider, in particular, the partner' s possible concerns about having his or her relationship with the client revealed to the provider. By considering this issue in advance, the client and the provider can anticipate the partner' s possible reactions and discuss how to respond appropriately.

Contract Referral. The other variation on provider and client referral, the contract-referral approach, might require more negotiation skill on the PCRS provider' s part. In the contract-referral approach, the provider and client decide on a time frame during which the client will contact and refer the partners. If the client is unable to complete the task within that agreed-upon time period, the PCRS provider then has the permission and information necessary to serve the partner. The provider must also have agreement with the client about how to confirm that partners were notified and what follow-up is required for situations where the client does not make the notification. Negotiation skill and a relationship of trust are needed so that the provider will have the identifying and locating information immediately available if the client does not inform the partner before the time limit expires.

When the contract-referral approach is used, the PCRS provider should also negotiate a provision with the client whereby the partner confirms in some way (e.g., telephone call, appointment for services) to the provider that he or she has been informed of being at risk. Otherwise, the provider may have difficulty knowing which partners have been informed and whether or not provider referral or some other assistance is now needed.

3.3 Setting Priorities for Reaching Partners

The PCRS plan must include prioritizing which sex or needle-sharing partners need to be reached first, based on each client' s and partner' s circumstances. Ideally, all partners should be reached, but limited program resources usually dictate that priorities have to be set. Priorities are determined by deciding (1) which partners are most likely to be already infected and to transmit infection to others; (2) which partners are most likely to become infected; and (3) which partners can be located. Priority is also affected by federal and state laws. For example, **federal legislation requires that a good-faith effort be made to notify "any individual who is the marriage partner of an HIV-infected patient, or who has been the marriage partner of that patient at any time within the 10-year period prior to the diagnosis of HIV infection."** (Public Law 104-146, Section 8[a] of the Ryan White CARE Reauthorization Act of 1996.)

A number of factors influence how the PCRS provider and client decide which partners need to be reached first. Obviously, if the client has had only one partner during his or her lifetime, that partner is likely to be infected. When the client has had more than one partner, other factors then have to be considered, such as the following:

- **Possible Transmission of HIV to Others.** The partner who is most likely to transmit HIV to others must receive highest priority. A partner who is a pregnant woman should be reached as soon

as possible for counseling, testing, and referral to medical treatment if infected, to avoid perinatal transmission. Likewise, the partner who the client knows has multiple other sex and needle-sharing partners needs to be reached as soon as possible to reduce the potential for transmission of HIV to others.

- **Partners of a Recently Infected Client.** If, for example, the client had a negative HIV test result 6 months ago, but now the test result is positive, partners within that 6-month time period or in the potential "window period" that preceded the negative test would receive priority. These partners are more likely to have acquired or been exposed to HIV than any of the client' s partners during the period before the client's HIV negative test. Other evidence of a recently infected person might be indicated by the exposure history of the client, e.g., client with a history of negative test results, findings from less sensitive EIA or serologic testing algorithm for recent HIV seroconversion, or other evidence of recent infection.
- **Likelihood of the Partner Being Unaware of Exposure to HIV.** Some individuals are less likely than others to suspect a risk for HIV infection or to understand what being "at risk" means. For example, many heterosexual women might be less aware of their HIV risk and therefore less likely to access counseling, testing, or other prevention services without PCRS.
- **Partners at Continued Risk.** Reaching the client' s current, recurring, or recent partners is a high priority because those partners might be at continued risk of becoming infected with HIV, if not already infected.
- **History of Other STDs.** Either the client' s or partner' s history of other STD infections is an important factor in setting priorities. For example, if a partner was treated for another STD, that partner is more likely to also be infected with HIV and, additionally, more likely to transmit HIV to others. If the HIV-infected client has a recent history of other STD infection, then his or her sex partners are more likely to have been HIV-infected, especially those exposed during the STD infection (Wasserheit, 1992).
- **Transmission of Strains of HIV that are Resistant to Antiretroviral Therapies.** If information or evidence exists that the client is infected with a strain of HIV resistant to antiretroviral therapies, partners of this client would have high priority for PCRS services.

The PCRS provider and client should begin by noting current or recent partners and the details of their exposure. Next, working back in time, they should consider any other partners who need to be contacted. By briefly noting the circumstances for each partner and then moving quickly on to the next one, the provider will be better able to stimulate the client' s memory. Then, together, they can determine the priorities for reaching as many partners as program resources might permit. Because determining when a client was actually infected or the circumstances associated with individual partners is often difficult or impossible, some HIV prevention programs routinely attempt to locate and counsel all partners from a defined time period. This time period, often 1-2 years, frequently is based on availability of resources for PCRS. Programs with greater amounts of resources, those with lower morbidity, or those that give higher priority to PCRS frequently attempt to reach and counsel partners exposed over a longer time period.

Once the provider and client have established which partners are to be reached, they can begin discussing a plan for reaching these partners. For those partners the provider will be contacting, exact locating information, plus the dates, types, and frequency of exposure should be noted (See Section 4.2). During this phase, new information about partners might come to light that necessitates adjustments in the priorities previously established.

In addition to the factors listed previously, the PCRS provider must also consider federal legislation and relevant state laws that require a good-faith effort be made in notifying current spouses or persons who have been spouses of a known HIV-infected person during the 10 years prior to the client' s diagnosis of HIV infection. Both the program policies of PCRS and the efforts of individual providers contribute to the required good-faith effort.

PCRS providers can satisfy the requirement of a good-faith effort by (1) asking all HIV-infected clients if they have a current or past marriage partner(s), (2) notifying these partners of their possible exposure to HIV, except in situations when, in the judgment of public health officials, there has been no sexual exposure of a spouse to the known HIV-infected individual during the relevant time frame; (3) referring them to appropriate prevention services; and (4) documenting these efforts. Programs need to have or develop policies to guide providers in situations in which the HIV-infected client does not give consent and will not allow the provider to notify his or her current or past marriage partner(s).

STANDARD: The PCRS provider and HIV-infected client must prioritize reaching partners based on who is most likely to transmit infection to others and who is most likely to become infected.

3.4 Considering Other Options and Special Circumstances

3.4.1 Other Persons Who Might Need To Be Contacted

While the PCRS plan is being developed and priorities are being set for reaching partners, the provider should take special note of any other persons being mentioned who might be at risk. For example, during interviews or counseling sessions, the HIV-infected client might discuss other persons who are not sex partners but are involved in a sexual or drug-injection network with high risks of HIV transmission. Another example is children or newborns that might have been exposed perinatally or through breast-feeding. Although not direct sex or needle-sharing partners of the HIV-infected client, these other persons should be offered HIV prevention counseling and testing, if resources and program policies permit. General information obtained through PCRS, not just a person' s name, can be used to identify high-risk places and venues where PCRS programs can provide outreach services. CDC encourages such efforts to identify and lower risks of HIV and other STDs within sexual or drug-injection networks and is interested in working with state and local health authorities to develop methods and more detailed guidance on network identification, analysis, and intervention.

3.4.2 "But, I Do Not Want My Partner to Be Contacted!"

Unfortunately, in some cases HIV-infected clients initially will simply not want their partners notified. For example, they might fear loss of anonymity, the breakup of a relationship, or other adverse consequences. Clients might say that partners have already been informed about their risks or that partners would not be interested in counseling, testing, or other support services. Providers can encourage a client' s participation by explaining that the partner benefits by knowing his or her HIV status and being able to seek immediate treatment if infected. Also, if infected, the partner can avoid transmitting the virus to others. However, when a client is determined not to disclose partner names, the PCRS provider should counsel the client as if he or she has chosen the client-referral approach.

Sometimes a client might not want his or her partner notified because of fear of a violent reaction from the partner. It is not uncommon for persons receiving public health services to report having experienced violence in their lives (Maher, 1998). Therefore, providers should be aware of the potential for partner violence and should be prepared to make appropriate referrals. If the provider has indication of a potentially violent situation for the client or others, the provider must make an assessment prior to notifying the partner and seek expert consultation before proceeding. States have varying legal requirements about reporting situations such as those involving violence or child abuse. The PCRS program must comply with relevant state laws and local regulations.

In some cases, the provider knows of a partner at risk even though the client has not identified that partner. Whether or not a legal "duty to warn" such partners (or identified partners that the client did not want notified [see Appendix B]) exists is best determined by reviewing applicable state laws or regulations, especially regarding spousal notification. All states must have a policy established to guide health

department staff in situations in which an HIV-infected client indicates he or she does not plan to notify known partners and will not provide the information necessary for the health department staff to make the notification.

The Association of State and Territorial Health Officials recommends in its 1988 *Guide to Public Health Practice: HIV Partner Notification Strategies* that a health care provider may invoke his or her "privilege to disclose" (see Appendix B) when that provider knows of an identifiable at-risk partner who has not been named by the HIV-infected person. State and local HIV prevention program managers should consider the ASTHO recommendations and their own relevant laws when developing policies and procedures.

STANDARD: CDC-funded PCRS providers must review with the HIV-infected client in appropriate detail the legal and ethical reasons for informing sex and needle-sharing partners of their possible exposure to HIV.

3.4.3 PCRS for Needle-sharing Partners

Sharing of needles, syringes, and other paraphernalia used for injection drug use (e.g., illicit drugs, steroids) carries high risk for transmission of HIV. Throughout this document, the importance of providing partner counseling and referral services to HIV-infected clients with needle-sharing partners is emphasized. CDC recognizes that some HIV prevention programs have relatively limited experience in working with needle-sharing partners and that special issues exist relating to clients disclosing information about such partners, reaching such partners, deciding which prevention interventions should be provided, and referring them for needed services.

Some state and local HIV prevention programs have already gained considerable experience in reaching and serving needle-sharing partners and report that such services are feasible and likely to be effective. For example, Levy and Fox (1998) reported that injection drug users infected with HIV want to notify their sex and needle-sharing partners and are willing to participate in the PCRS process. Information provided by HIV-infected clients who are injection drug users may help HIV prevention program managers gain insight into the extent and types of prevention service needs of injection drug users and how best to deliver and target such services.

CDC will provide expanded guidance on PCRS for needle-sharing partners in future versions of this guidance.

4.0 LOCATING AND NOTIFYING PARTNERS

4.1 Preparing the PCRS Provider

In large part, the manner in which PCRS is provided to and perceived by the affected communities determines how successful HIV prevention programs will be (see Section 4.5). Therefore, program managers and supervisors should ensure that PCRS staff -

- are skilled and competent in providing PCRS;
- are culturally competent and demonstrate respect for the community to be served;
- are knowledgeable about HIV infection, transmission, and treatment;
- are knowledgeable in local, state, and federal laws regarding HIV and other relevant issues of providing health care, especially the right to privacy and confidentiality;
- receive updated information and periodic retraining as appropriate;
- have standards, objectives, and specific guidelines for performance;

- are appropriately supervised and given written and oral feedback about their performance on a regular basis; and
- have appropriate problem-solving skills to deal with situations that might be encountered in a field setting, e.g., personal safety, violence to others.

In addition to receiving formal training, such as CDC' s training course on PCRS, an inexperienced PCRS provider should complete an internship by being teamed with a more experienced provider for a period of time before conducting PCRS alone (see Section 6.1). Another way to enhance a provider' s performance is through routine peer review of selected cases.

Providers of successful PCRS programs regularly go outside the clinic or office setting to reach partners. The inexperienced provider will need training in deciding when to deliver PCRS outside the office or clinic and when to postpone PCRS. Benefits of delivering PCRS in a partner' s home might include providing the partner with a familiar environment and helping the provider better understand the personal circumstances of that partner. Whether or not to do PCRS outside the clinic or office, or whether it is best postponed until an adverse situation can be resolved, must be decided on a case-by-case basis. In addition, training in avoiding confrontations, diffusing anger, and mediating disputes will better prepare any provider for handling potentially violent situations.

STANDARD: Program managers and supervisors must ensure that each PCRS provider has the appropriate training and skills to effectively serve HIV-infected clients and their partners.

4.2 Setting Activities in Motion

For those partners the provider will be contacting, the first step the provider should take is to verify the identifying and locating information given by the HIV-infected client. Locating and notifying partners should begin as soon as possible after the provider and HIV-infected client have decided on the best approach to use for each partner and priorities have been set for reaching partners. If the client will be informing partners, the client should be well-coached on how to do so and should be provided opportunities to obtain additional counseling, assistance, or other support during the process.

STANDARD: Locating and notifying activities must begin promptly once the PCRS plan has been formulated and the priorities set for reaching partners.

4.3 Maintaining Confidentiality

Confidentiality for all persons involved in PCRS must continue to be maintained. All attempts to make contact with a sex or needle-sharing partner should be confidential. This is often difficult because other community members might ask the purpose of the provider' s visit and why he or she is attempting to make contact. Nevertheless, providers should not, for example, reveal to others why they are trying to find a particular person. Likewise, providers should never leave a note or message that mentions HIV exposure as the reason for attempting to make contact. In addition, no other information should be revealed that might lead to others learning the reason for the contact or that might otherwise lead to disclosure of sensitive information or to a breach of confidentiality. As each partner is located, he or she should be informed privately and face-to-face, if at all possible. However, if the person refuses to meet with the provider, informing a partner by telephone might become necessary. In such situations, only limited information should be provided to the partner, and the goal still should be to arrange a face-to-face meeting if at all possible. Informing a partner by telephone should only be done as determined by state and local jurisdictions and after every step has been taken to ensure that the correct person has been located, is on the telephone, and others are not listening. Further attempts should be made to arrange a meeting in person.

The original HIV-infected client will sometimes inquire about the results of the PCRS provider' s activities regarding his or her partners. The provider, when requested, can reveal whether a particular partner has been informed of his or her exposure to HIV, but must not reveal any confidential information about that partner, including whether the partner decided to be tested or whether he or she is HIV-infected.

Of equal importance is not revealing any identifying information about the original client to the partner, including the person' s sex, name or physical description, or time, type, or frequency of exposure. Although the PCRS provider will need to document the results of his or her activities in a thorough, concise, and timely manner, confidentiality must still be maintained for all persons involved. Information that identifies partners should be kept locked in a secure location. Client and partner information, other than the official record (as determined by state practice), should be destroyed when current PCRS activities are concluded.

State or local areas should establish PCRS record-keeping policies and procedures, and client and partner information should be maintained in accordance with these policies. Many public health programs have developed policies and procedures to safeguard sensitive client or partner information. One example can be found in CDC's *Guidelines for HIV/ AIDS Surveillance*, Appendix C, Security and Confidentiality (as revised October 1998). In developing their policies, PCRS managers can choose to review and adapt the policies and procedures in this document or those of other public health programs.

STANDARD: While conducting PCRS activities in the community, providers must continue to maintain confidentiality for all HIV-infected clients and their partners.

4.4 Helping Partners Access Services

The PCRS provider must be well prepared to handle the initial reactions of the person who is being informed of possible exposure to HIV. That person will undoubtedly need immediate counseling, followed by referral to additional HIV prevention counseling. The provider must be prepared to answer the questions and concerns of each partner without revealing any identifying information about the original HIV-infected client.

As described earlier, referring partners to needed prevention, treatment, and other relevant services is a goal of PCRS. Testing is a very important issue to persons who have just learned of possible exposure. The provider must be prepared, at a minimum, to refer them to counseling and testing services. For many years, providers have taken blood specimens of those who consent at the time of notification, which requires specialized training. With the current availability of oral fluid and urine collection kits, and rapid testing systems, program managers are encouraged to consider providing on-the-spot collection of specimens for HIV testing as each partner is informed. If the partner has previously been tested, and those results were negative, the PCRS provider should stress the need to follow up with another test if exposure history indicates it is warranted.

However, many partners will need referrals for other kinds of social and medical support services beyond counseling and testing. The PCRS provider should already have agreements in place and an up-to-date resource guide so that immediate referrals can be made to services such as substance abuse treatment, family planning assistance, other STD treatment, domestic violence prevention, mental health counseling, or housing assistance (CDC, 1993). Having agreements in place for collaboration between PCRS providers and referral sources will help ensure that those services can be successfully accessed. PCRS providers should then follow up with each partner contacted to ensure that test results and other referral services have in fact been received. If providers in another health jurisdiction have been asked to contact a partner, health departments should follow up with that provider to determine that services have been received.

STANDARD: As each partner is informed of possible exposure to HIV, the PCRS provider must

be prepared to assist that person with immediate counseling and referrals for more intensive counseling as well as testing and other support.

4.5 Addressing Community Concerns

The potential exists for PCRS to have a negative impact on HIV-infected individuals, their partners, or affected communities (Rothenberg and Paskey, 1995; West and Stark, 1997). Some community leaders view these kinds of activities with suspicion and are apprehensive about such issues as -

- whether disclosure of partner names is done voluntarily;
- possible denial of health care or other services if the HIV-infected client refuses to reveal partner names or otherwise refuses to cooperate with the provider;
- unintended effects on personal relationships, such as partnership breakup or violence;
- potential for invasion of privacy or loss of confidentiality for HIV-infected clients and their partners; and
- possible discrimination if confidential information held by government agencies is ever released, either accidentally or by law.

Although PCRS providers cannot always resolve these issues, they can strive to build relationships of trust between themselves and those they serve, including the leaders of affected communities. Working with HIV prevention community planning groups and others when determining and evaluating priorities, policies, and procedures for PCRS will help increase community support and acceptance. PCRS providers should be prepared, whenever an opportunity arises, to address legitimate concerns and dispel misconceptions about policies and practices (West and Stark, 1997).

5.0 COLLECTING, ANALYZING, AND USING PCRS DATA

5.1 Why Collect Program Data?

PCRS data must be collected and used (1) to assess the behavioral risks for sex and needle-sharing partners of HIV-infected persons; (2) to evaluate the effectiveness of the PCRS program as part of the overall HIV prevention effort; and (3) to improve how other HIV prevention activities, interventions, and services are implemented.

Accurate and consistent data collection is a critical component for evaluating how effective the PCRS program is, as well as how well it enhances the overall HIV prevention intervention (CDC, 1994). Moreover, PCRS data enable providers to better focus prevention efforts on those persons most at risk. When the data reveal information about networks of people who are having sex or injecting drugs, the dynamics of HIV transmission can be better analyzed (Fenton and Peterman, 1997), and more intensive prevention and education efforts can be applied for specific high-risk groups (West and Stark, 1997). To do all this, however, the collected data must be relevant to behavioral risks, HIV/AIDS prevalence, and the demographics of affected communities. With accurate and consistent data, the staff of health departments and community-based organizations and members of HIV prevention community planning groups can establish an effective mix of prevention strategies.

5.2 What Data Should Be Collected?

Any data collection tool used in a PCRS program should be designed so that certain core information can be ascertained, including answers to the following:

- What proportion of HIV-infected clients is offered PCRS?
- What are the reasons those clients either reject or accept PCRS?
- What is the range of PCRS services (e.g., client referral, provider referral, combinations of referral approaches) offered to and accepted by each client?
- How many sex or needle-sharing partners are identified?
- What is the percentage of partners actually reached through PCRS, and how many of those partners are HIV-infected? Of those partners who are HIV-infected, how many are being informed of their infection for the first time?
- What are the demographics (e.g., marital status, age, sex, race/ethnicity) of the clients and partners actually served?
- How many partners are offered referral services? How many receive these services? In what time frame do they receive referral services?

And, perhaps most importantly, PCRS program managers should routinely assess what all of this information means in regard to how well PCRS is working for HIV-infected clients, their partners, and the community at large. Are clients served well? Are partners gaining access to services that might not be otherwise available? Are communities becoming more supportive of public health efforts? Does evidence exist that risks are being reduced? Are other prevention program services better targeted to communities in need?

The HIV prevention program managers in each health jurisdiction should decide how best to collect, analyze, and use PCRS data. This should be done in a manner that is consistent with the policies and procedures that they have developed to safeguard the security of the data and the confidentiality of the client or partner (see Section 4.3). Those managers should keep in mind that misconceptions about the collection and use of HIV data, in addition to a general mistrust of publicly funded agencies, are two of the biggest barriers to HIV prevention efforts in affected communities. CDC plans to work with state and local HIV prevention and STD prevention and treatment programs to develop proposals for standardizing the collection and analysis of PCRS data.

STANDARD: CDC-funded PCRS providers must collect data that help answer questions about how well the PCRS program is functioning; the extent and quality of services being provided; the degree to which clients and their partners accept and are satisfied with services; and how PCRS and other prevention services can be enhanced.

STANDARD: CDC-funded PCRS providers must use standardized data collection tools throughout the program that maintain the privacy or confidentiality of the original HIV-infected client and his or her partners.

6.0 ENSURING THE QUALITY OF PCRS

6.1 Training

Of all the resources necessary for the successful operation of PCRS programs, training is perhaps the most critical (Fenton and Peterman, 1997). Each individual PCRS provider must receive initial basic training plus periodic updates on how to conduct PCRS (including its scientific rationale), provide client-centered counseling, protect individuals' rights to privacy, use scientific information in prioritizing

partners, administer HIV tests when appropriate, and defuse potentially violent situations involving clients, partners or staff (see Section 4.1). PCRS providers also need to understand laws regarding confidentiality of medical records.

STANDARD: PCRS providers must be well trained to provide effective PCRS services.

6.2 Quality Assurance and Evaluation

Quality assurance for PCRS programs entails ensuring that appropriate and standardized methods are used for -

1. counseling HIV-infected clients regarding the notification of their partners;
2. developing a PCRS plan with HIV-infected clients;
3. prioritizing which partners are to be reached;
4. locating and informing those partners of their possible exposure to HIV;
5. providing immediate counseling and testing services to informed partners and/or referring them to other service providers; and
6. collecting, analyzing, using, and storing PCRS data.

Written job descriptions, including minimum performance criteria, and comprehensive procedures for delivering quality PCRS should be developed and copies made available to all personnel. Also, supervisors should directly observe a new PCRS provider until confident that the provider is proficient in serving clients and their partners. Then, through periodic supervisor observation, peer review of selected cases, and "customer" satisfaction surveys, each PCRS provider should be given constructive oral and written feedback.

PCRS programs should include policies relevant to situations in which an HIV-infected person knowingly exposes others to HIV. These policies must comply with relevant state or local laws.

The overall program should also be regularly evaluated to determine the quality of effort and the success in reaching the PCRS goals (Fenton and Peterman, 1997) (see Section 1.2). Program evaluations should include a comprehensive assessment of all confidentiality procedures that includes, at a minimum, record-keeping.

STANDARD: CDC-funded PCRS programs must have a quality assurance plan.

STANDARD: CDC-funded PCRS programs must evaluate their services.

6.3 How Can CDC Help?

Many types of technical assistance are available for designing, managing, or evaluating PCRS through CDC' s project officers, program consultants, and network of HIV prevention partners. In addition, training is provided through CDC and its contractors that is designed to enhance PCRS providers' skills regardless of their level of experience. Finally, information on the latest scientific findings about HIV is available through the CDC National Prevention Information Network (toll-free, 800-458-5231).

Health Communications / Public Information (HC/PI)

Health Communications/ Public Information is the delivery of HIV prevention messages through one or more channels to target audiences to build general support for safe behavior, support personal risk-reduction efforts, and/or inform persons at risk for infection how to obtain specific services. Health communications and public information can be delivered using the following means:

Electronic Media: Means by which information is electronically conveyed to large groups of people; includes radio, television, public service announcements, news broadcasts, infomercials, etc., which reach a large-scale (e.g., city-, region-, or statewide) audience.

Print Media: These formats also reach a large-scale or nationwide audience; includes any printed material, such as newspapers, magazines, pamphlets, and "environmental media" such as billboards and transportation signage.

Hotline: Telephone service (local or toll-free) offering up-to-date information on HIV/AIDS and referral to local services, e.g., counseling/testing and support groups.

Clearinghouse: Interactive electronic outreach systems using telephones, mail, and the Internet/Worldwide Web to provide information to the general public as well as high-risk populations.

Presentations/Lectures: These are information-only activities conducted in group settings; often called "one-shot" education interventions. Workshops and presentations are typical activities of community outreach. Because they usually follow lecture formats, they can be highly structured health education and risk reduction intervention efforts. While they supply important opportunities to disseminate HIV/AIDS prevention information, their impact on behavior change is limited because they are usually single-encounter experiences. Although they provide crucial information that raises awareness and increases knowledge and may be a critical first step in the change process, the information alone is usually inadequate to sustain behavior change.

One example of this type of activity is **Community Workshops and Presentations**, which are one-shot activities in which participants are provided with basic information on HIV/AIDS.

Standards for Community Workshops and Presentations

In a workshop or presentation, audience participation is to be strongly encouraged. Time must be allotted, usually at the end of the presentation, for a question and answer session. However, some questions may be so pressing, or some participants so persistent, that the presenter will have to address some questions and concerns during the presentation. Elements for a successful Community Outreach presentation include:

1. Speakers who are members of the target population of the audience.
2. A comprehensive workshop/presentation curriculum.
3. Assurance that curricula provide for discussion of related issues.
4. Detailed workshop/presentation outlines.
5. Methods to assure that the audience is informed about workshop/ presentation goals and objectives and that discussion of subject matter is facilitated.
6. Descriptions of skills-building exercises relevant to the program's objectives.
7. Referrals to agencies, hotlines and community information resources.

CDC Guidelines for Workshops and Presentations

From the CDC "Guidelines for Health Education and Risk Reduction (HERR) Activities, March 1995

Workshops and presentations are typical activities of community outreach. Because they usually follow lecture formats, they can be highly structured health education and risk reduction intervention efforts. While they supply important opportunities to disseminate HIV/AIDS prevention information, their impact on behavior change is limited because they are usually single-encounter experiences. Although they provide crucial technical information that raises awareness and increases knowledge and may be a critical first step in the change process, the information alone is usually inadequate to sustain behavior change.

To maximize their benefit, workshops and presentations should be planned carefully with knowledge goals and objectives specified before the individual sessions. To the extent possible, presenters should be informed about the setting where the workshop or presentation will take place, as well as the composition and knowledge level of the anticipated audience. The following are examples of issues the presenter might consider before conducting a presentation or workshop:

- Where will the workshop or presentation be held?
- What is the age range of the participants/audience?
- What is the language(s) of the participants/audience?
- What audiovisual equipment is available?

A well-planned, detailed outline, which allows flexibility, can prove useful and beneficial to the presenter and the participants/audience. Such an outline helps keep the presentation on track and focused. If a pretest evaluation is to be used, an outline can ensure that all relevant material will be covered in the lecture.

In a workshop or presentation, audience participation is to be strongly encouraged. Time must be allotted, usually at the end of the presentation, for a question and answer session. However, some questions may be so pressing, or some participants so persistent, that the presenter will have to address some questions and concerns during the presentation. The presenter should answer the questions succinctly and return to the original order of the presentation.

To increase the number of workshops and presentations they are able to provide, some agencies will elect to develop speaker's bureaus to augment their paid staff. Recruitment, training, and retention of volunteers present complex programmatic questions and are not to be undertaken lightly. Several references related to volunteers are provided at the end of this document and should be reviewed carefully.

A more detailed list of important points to consider for workshops and presentations is contained in Appendix C. The points below are relevant to agencies providing workshops and presentations either by paid staff or by volunteers in a speaker's bureaus. Effective presenters:

- Possess organizational and public speaking skills.
- Are well-informed and comfortable talking about the subject.
- Ensure that the presentation is linguistically appropriate for the audience.
- Elicit and encourage audience participation.
- Are adaptable to logistics and audience needs.
- Are non-judgmental.
- Assess the nature of questions to make appropriate responses, i.e., whether better answered in private.
- Seek accurate answers to difficult questions and provide information in a timely manner.

A few items specifically needed in a Community Outreach Program Plan are listed below.

- A comprehensive workshop/presentation curriculum.

- Assurance that curricula provide for discussion of related issues.
- Detailed workshop/presentation outlines.
- Logistical guidance for workshops/presentations (e.g., time and location, room arrangement, number of participants, number of facilitators).
- Methods to assure that the audience is informed about workshop/ presentation goals and objectives and that discussion of subject matter is facilitated.
- Descriptions of skills-building exercises relevant to stated program objectives.
- Training in the operation of audiovisual equipment and the use of diverse forms of audiovisual equipment.
- Recruitment of staff with organizational and public speaking skills.

Standards for Effective Public Information Programs

- Public information activities must support other components of health education and risk reduction activities.
- Target audiences for public information activities must be selected, based on needs identified through the community needs assessment.
- Objectives for public information must be based on a realistic assessment of what communications can be expected to contribute to prevention.
- Messages must be based on the target audience's values, needs, and interests.
- Messages and materials must be pretested with the target audience to assure understanding and relevance to their needs and interests.
- Community representatives must be involved in planning and developing public information activities to ensure community "buy in."

CDC Guidelines for Public Information

From the CDC "Guidelines for Health Education and Risk Reduction (HERR) Activities, March 1995

The Role of Public Information in HIV/AIDS Prevention

Public information activities alone do not represent a sufficient HIV prevention strategy. However, planning and implementing effective and efficient public information programs are essential to successful HIV/AIDS prevention efforts.

As defined here, the purposes of public information programs are to:

- Build general support for safe behavior.
- Support personal risk reduction.
- Inform persons at risk about infection and how to obtain specific services.
- Encourage volunteerism.
- Decrease prejudice against persons with HIV disease.

Public information programs craft and deliver data-driven and consumer-based messages and strategies to target audiences.

The public information program standards and guidelines set forth here are based on CDC's standards for health communication.

Definitions

CDC defines health communication as a "multidisciplinary, theory-based practice designed to influence the knowledge, attitudes, beliefs, and behaviors of individuals and communities" (Roper, 1993). Sound health communication practice is based on a combination of behavioral and communication sciences, health education, and social marketing. Current practice extends beyond information dissemination to include a variety of proactive strategies addressing both individual and societal change.

A communication (public information) program is the delivery of planned messages through one or more channels to target audiences through the use of materials.

Successful public information programs share a number of basic characteristics, which include:

- A person in charge who manages the program well.
- Activities planned to fit what the community and target audience need and want.
- A variety of activities, including mass media, that can be directed over a period of time to the target audience.
- A measurable program objective or purpose.
- A commitment to evaluation -- tracking and measuring progress toward objectives.
- A time schedule.
- Efficient use of people and other resources.
- Well-planned and well-executed health communication in public information programs can accomplish the following:
- Raise awareness.
- Increase knowledge.
- Refute myths and misconceptions.
- Influence attitudes and social norms.
- Reinforce knowledge, attitudes, and behaviors.
- Suggest and enable action.
- Show the benefits of a behavior.
- Increase support and/or demand for services.
- Help coalesce organizational relationships.

Public information programs should use multiple approaches to motivate and involve people and communities. Using health communication methodologies, however, is not sufficient to guarantee change. Plans for creating sustained behavior change should include information/communications in combination with other prevention strategies. In this way, effective communications can significantly enable and contribute to change. For example, public information programs funded by CDC carry out parts of CDC's overall HIV prevention strategy. Consumer-influenced messages and strategies are best achieved by a systematic approach involving research, planning, implementation, evaluation, and feedback. The purpose of this section is to offer guidelines for conducting public information programs that have been developed as integral parts of an overall HIV-prevention strategy.

In addition to planning, pretesting, and evaluating public information strategies, specific components of public information programs -- producing educational materials, working with the print and broadcast media, hotlines, and special events -- are addressed here.

Planning for Public Information

To be effective, public information programs must be consistent with and supportive of broader programmatic objectives (e.g., to inform target audiences about and motivate them to use existing HIV counseling and testing services). Therefore, public information plans should be developed as one component of the comprehensive HIV prevention plan.

During the planning process, a number of key questions should be asked. The answers, which should be derived from targeted needs assessment data, will help to assure that public information efforts will support the HIV/AIDS prevention program objectives. These questions cover the following issues:

- What are the media preferences and habits of the target audience? What information sources (such as social networks, churches/religious institutions, coaches) do they consider credible?
- What are the media and other organizations that provide information in the targeted area? Which activities are related to public information? What are the specific audiences?
- What prevention program goals and objectives can public information support (e.g., increased knowledge, change in attitudes, motivation to act, increased skills, other behaviors)?
- What services/program activities should be promoted?
- What measurable objectives can be established? How can progress be tracked?
- What are the broad message concepts for the target audience? What should they be told? What do they want to know? Who will they believe and trust?
- What communication channels are most appropriate for reaching target audiences (e.g., radio, TV, print media, worksite, face-to-face, voluntary organizations, or the health care sector)?
- What materials formats will best suit these channels and messages? Are there any existing materials that can be used or adapted?
- How can the resources be used most effectively and for what combination of activities?
- In addition to answering these key questions, an important part of the planning process is determining the short- and long-term objectives of the public information program. Objectives could include the following:
- Increase the number of persons (target audience) calling a hotline or requesting information/expressing an interest in other ways.
- Increase the number of program participants, volunteers, and requests for activities within a community.
- Increase beliefs among community leaders that support for HIV/AIDS issues is important.
- Increase the numbers of partner, family, or other discussions about HIV/AIDS.
- A comprehensive program could include all of these objectives. Most communities may find that they can take on one or two objectives at a time, then add to or alter their program focus as the program develops or community needs change.

Staff Training in Planning for Public Information

Staff working in public information programs should review, discuss, and receive training based upon the CDC health communication framework or a similar planning model such as that found in Making Health Communication Programs Work: A Planner's Guide. (National Institutes of Health. NIH Publication No. 89-1493. Bethesda, MD: U.S. Department of Health and Human Services, 1989.)

Staff should also be familiar with methods for tracking and evaluating public information activities.

Channel Selection

Communication channels are the routes or methods chosen to reach the target audiences. Types of channels include mass media, interpersonal transactions, and community-based interactions. Understanding the advantages and disadvantages of communication channels can help assure the best use of each, including the coordination of mass media activities with other strategies where beneficial. Each channel has its own characteristics and advantages and disadvantages, as listed here:

MASS MEDIA (radio, television, newspapers, magazines)

Advantages:

- can reach many people quickly
- can provide information
- can help change and reinforce attitudes
- can prompt an immediate action (e.g., calling toll-free
- number)
- can demonstrate the desired action

Disadvantages:

- are less personal and intimate
- are less trusted by some people
- do not permit interaction
- offer limited time and space
- offer limited opportunities to communicate complex
- or controversial information alone, usually cannot
- change behavior
- can be costly

COMMUNITY CHANNELS (schools, employers, community meetings and organizations, churches/religious institutions, special events)

Advantages:

- may be familiar, trusted, and influential
- may be more likely than media alone to
- motivate/support behavior change
- can reach groups of people at once
- can sometimes be inexpensive
- can offer shared experiences

Disadvantages:

- can sometimes be costly
- can be time consuming
- may not provide personalized attention

INTERPERSONAL CHANNELS (e.g., hotline counselors, parents, health care providers, clergy, educators)

Advantages:

- can be credible
- can permit two-way discussion
- can be motivational, influential, supportive

Disadvantages:

- can be expensive
- can be time consuming
- can have limited target audience reach

Selecting the Appropriate Channel

The appropriate channel or channels for a specific project can be selected by assessing whether the channel is:

- Likely to reach a significant portion of the target audience. (Local media outlets can provide a demographic profile of their viewers/ readers/listeners.)
- Likely to reach them often enough to provide adequate exposure for the message/program.
- Credible for the target audience.
- Appropriate and accessible for the selected HIV/AIDS message.
- Appropriate for the program purpose (e.g., provide new information versus motivate action).
- Feasible, given available resources.

Choosing multiple channels can help combine the best traits of each and reinforce the message through repetition. For example, a major daily newspaper may reach the most people. Adding stories in a local African American newspaper may provide credibility within that community, and publicizing the hotline in these stories can help the reader get more information tailored to his or her needs.

Educational Materials

Educational materials are learning or teaching aids. They can be used to reach masses of people, to reinforce or illustrate information given in a one-on-one setting, or serve as references to remind people of information they received earlier. Materials also teach skills by providing hands-on experience or by illustrating a step-by-step approach. Effective materials can also influence attitudes and perceptions.

Development or selection of educational materials is directed by several considerations:

- What is the public information objective? Is it to inform, demonstrate, persuade, or remind? These considerations determine how educational materials are designed and used.
- Who is the target audience? Where (which channels) can they be reached? Are there any target audience preferences for types of materials (e.g., non-print for low-literacy audiences, fotonovelas for Latinas)?
- What is the specific message? Is it a skill, an attitude to be considered, medical information, a negotiation approach, or a synopsis of previous instruction?
- What materials are already available? Will they fit the audience, channel, and objective? Can they be purchased? Reproduced? Modified?
- What financial, staff, and other resources are available for materials development? Should development be handled in-house or by contract?

Choose Formats for Education/Information Materials

In selecting formats for educational and informational materials, choice should be guided by the amount and type of information to be presented, the channels to be used, and target audience preferences. For most messages, using as many different formats as appropriate will provide more options for message promotion. Commonly used formats include:

Channel: Television

Formats: Public service announcements, paid advertisements, editorials, news releases, background or question and answer (Q and A) for public affairs programs

Channel: Radio

Formats: Live announcer copy (PSAs), taped PSAs, topic ideas for call-in shows

Channel: Newspaper

Formats: News releases, editorials, and letters to the editor

Channel: Outdoors
Formats: Transit ads, various sizes
Billboards, various sizes
Ads/posters for bus stop enclosures, airports

Channel: Community

Formats: Posters for beauty and barber shops, pharmacies, grocery stores, worksites
Bill inserts: shopping bag inserts or imprints, paycheck inserts Special event giveaways: calendars, fact cards, pencils, balloons, key chains
Table top or other displays for health fairs, waiting rooms, libraries, schools
Newsletter articles for community, employer, business newsletters Fotonovelas, flyers, pamphlets, coloring books for distribution through community settings

Channel: Interpersonal

Formats: Posters for physicians' offices and clinic waiting and examination rooms
Talking points, note pads for patient counseling, presentations at schools, organizations, religious institutions
Videos for classroom use

Review Available Materials

Before developing new materials, make sure that new production is necessary. If materials are available that will meet identified program needs, expense and effort can be saved. Contact the CDC National AIDS Clearinghouse (1-800-458-5231) to find out what is available.

Determine whether appropriate materials can be used or modified:

- Is the organization willing to share its materials? (Note: Virtually all materials produced by the Federal government are in the public domain. This means that they are not copyrighted and can be freely reproduced.)
- Can your program identity be substituted or added to the materials? (Make changes to fit planned public information activities.)
- Is the material available in the quantities needed? Is it affordable?
- Were the materials tested? With what results?
- How are the materials currently being used? By whom? With what effects?
- Are the materials suitable for the identified target audience and your community? (Testing may be needed to find out.)
- Are the messages consistent with specified public information and prevention program objectives?

Pretest Messages and Materials

Pretesting is defined as the testing of planned public information strategies, messages, or materials before completion and release to help assure effectiveness.

Pretesting is used to help make sure that messages and materials will work. It is important to test messages and draft materials with target audiences. Also, testing with media or other "gatekeepers" is a good idea, e.g., PSA directors or others who can influence whether messages and materials are used.

Pretesting can help determine whether messages and materials are:

- Understandable.

- Relevant.
- Attention-getting.
- Memorable.
- Appealing.
- Credible.
- Acceptable to the target audience.

These factors can make a difference in whether messages or materials contribute to meeting public information objectives.

The most frequently used pretest methods include:

- Focus groups.
- Self-administered questionnaires.
- Central location intercept interviews.
- Individual interviews.
- Theater-style testing.
- Readability testing.
- Gatekeeper review.

Specific pretest methods will vary, depending upon:

- Materials format(s).
- Complexity of the materials or messages (e.g., for complex messages, more time may be needed to explore audience reactions).
- Degree of sensitivity or controversy (e.g., a combination of methods helps make sure that responses are honest).
- Previous experience with or knowledge of the target group (i.e., less testing, or less in-depth exploration may be called for if a great deal is already known about audience views).
- Resources.
- The pretest questions to be explored.

Note: Additional information about pretesting can be found in Making Health Communication Programs Work: A Planner's Guide. (See Resources and References.)

Staff Characteristics for Materials Development and Pretesting

Staff who is involved in the development of educational materials should know the attributes and limitations of the educational materials formats to be used. In addition, they should:

- Speak, read, and write the language or dialect of the designated audience or have access to someone who does.
- Have the ability to identify accurately and incorporate appropriate literacy levels in design of materials.
- Communicate effectively in print and audiovisual media, or have access to competent materials producers.
- Be familiar with characteristics and life styles of designated audience.
- Be non-judgmental.
- Know the message and materials objective.

- Be able to personalize the material's message to be relevant to the target audience.
- Be able to design and conduct message and materials pretests or have access to trained and experienced help.
- Be able to design and implement distribution and promotion plans to assure appropriate use of materials to support public information activities.

Training for staff materials development and pretesting should:

- Emphasize how to design objectives, messages, and educational material.
- Instruct how to design and implement dissemination, promotion, and evaluation plans to assure appropriate use of materials.
- Inform about sources of additional information and related services.
- Teach how to determine appropriate motivator of behavior change.
- Instruct how to design and conduct pretests, including how to conduct focus groups.
- Provide practice sessions and opportunities for observation before conducting target audience pretests.
- Provide other training as needed (e.g., cultural sensitivity, low literacy materials development, sexuality attitudes, interviewing skills).

Using the Mass Media Effectively

The mass media is a vast and powerful sector of our society that includes television, radio, newspapers, magazines, other mass circulation print vehicles, and outdoor advertising. For HIV/AIDS prevention public information outreach, this category also can include shoppers' weeklies, newsletters published by businesses, periodicals distributed by organizations, newsletters from major employers, school/college newspapers, closed circuit television, and broadcast radio stations.

Opportunities for Messages in the Mass Media

The media offer more than news and public service announcements:

Beyond "hard" news, consider "soft" news that you help create:

- an upcoming activity;
- an event;
- findings from a public opinion poll or survey;
- a local angle to a national story;
- news appropriate for health or community features; and
- community advocacy of an issue that creates news.

For entertainment, consider:

- features in print or on television;
- talk and call-in shows;
- health and advice columns;
- consumers' own stories; and
- interviews with local personalities.

In addition to news or public service announcements for television and radio, ask for the following:

- businesses to sponsor paid advertisements or add an HIV prevention message to their ads;
- stations to include reminders as parts of station breaks;

- broadcast associations to help negotiate better rates for paid ads;
- the media to help in producing PSAs or video segments;
- consideration before a newspaper editorial board;
- placement of your spokesperson on news, public affairs, talk shows, call-ins, or editorial segments;
- paid advertisements; and
- co-sponsorship of events within the community.

Editorial time and space includes:

- letters to the editor; and
- print or broadcast editorials (e.g., on local policies, access to services).

What Makes News

Remember that you are competing with all the other news happening on a given day. Be sure that your story has something extra to offer, such as:

- Widespread interest or interesting angle.
- A local angle.
- Timeliness.
- Human interest.
- Controversy.
- Celebrity involvement.
- Impact on the community.

Note: CDC's two guides, HIV/AIDS Media Relations and HIV/AIDS Managing Issues, provide additional information for working with the mass media. Also, the National Public Health Information Coalition (NPHIC) has prepared a "hands-on" guide for handling media interviews.

Working with the Mass Media

Involve media professionals in planning. Like many other people, they prefer to be involved from the beginning and to feel their opinions are valued, not just their access to media time and space.

Develop a media contact list. The public information office of the state health department probably can get you started. Also, guidance is provided in CDC's Media Relations guide. (See References.)

Establish relationships with the media; concentrate on those media outlets your target population is most likely to see, hear, or read. Articulate a role for media that will contribute to objectives and capture the attention of the target population; build capacity to interact effectively with the news media.

Media relations can be labor intensive. To make sure that the efforts pay off, consider the following:

- Start with a media plan that includes a variety of strategies; coordinate that plan with other program strategies.
- Quickly and competently respond to media queries and deadlines.
- Plan media activities over time, rather than one event at a time.
- Track media results, report successes, and plan for improvement.
- Look for opportunities to turn existing events and stories into new angles to support the media strategy.
- Recognize the contributions of media, e.g., send letters.

- Periodically review what has been accomplished, what needs improvement, and what to do next.

To identify media strategies, consider:

- What has not been covered and could be covered.
- Which media outlets might be interested in doing more.
- Which journalists, columnists, or media personalities might be interested.

Media strategies should:

- Contribute to program objectives.
- Be within your means to accomplish.
- Consider benefits and limitations of business and other partners.

Prioritize media strategies by weighing expected benefits, resources required, and how each could be "sold" to the media. Then, work first on those with the greatest potential. Use information about the public's interest in HIV/AIDS to convince the media to participate.

Assess exposure in the media:

- Quantity -- how much coverage (seconds, column inches) was received.
- Placement -- where the coverage appeared in relation to the target audience's media habits.
- Content -- whether it was likely to attract attention (e.g., with a provocative headline or lead in), favorable, accurate, incomplete, misleading, or negative information.
- Feedback -- whether the target population and/or decision makers in the community responded in a tangible way.

Ways to track media efforts:

- Keep a log of media calls -- track what was said, identify who to call back, identify when coverage will occur; use the log to update media contact lists.
- Clip and review print coverage; tape to review television and radio coverage (purchase videos of coverage from stations or commercial sources when high-quality videos are needed, e.g., for presentations).
- Request from stations a monthly printout that lists when PSAs were shown and the time donated (dollar value).
- Include an audience prompt in messages, and monitor who responds.

Provide media spokesperson training for staff that works with the media. Staff training should also:

- Follow the recommendations in CDC's Media Relations and Managing Issues guides.
- Explore options for working with the media beyond PSAs, including establishing media relationships and message placement.

Other Interventions

This category is used for those interventions that cannot be described by the definitions provided for the other six types of interventions. This category includes community-level interventions (CLI). CLI are interventions that seek to improve the risk conditions and behaviors in a community through a focus on the community as a whole, rather than by intervening with individuals or small groups. This is often done by attempting to alter social norms, policies, or characteristics of the environment. Examples of CLI include community mobilization, social marketing campaigns, community-wide events, policy interventions, and structural interventions.

Community-level interventions are those that:

1. target the community (often defined by gender, geography, risky behaviors, race, ethnicity, or sexual orientation) rather than a specific individual;
2. involve community members in the actual design and delivery of the intervention; and
3. aim to change community norms about high-risk behaviors (as well as modify individual behaviors)" (Holtgrave et al., 1994).

Programs in this category may use multiple methods in order to influence community norms. These include social marketing (the application of marketing theory and strategies to the promotion of social change), community-based outreach (e.g., using indigenous community members to disseminate information), mass media (television, radio, newspapers, billboards), and small media (newsletters, posters, flyers).

One example of CLI is **Community Mobilization,** the goal of which is to increase awareness and knowledge of HIV/AIDS issues and to provide a foundation for the greater participation of people in general in HIV prevention and service activities. This intervention generally targets persons who are not at risk for HIV/AIDS as well as those who are at risk. Furthermore, community mobilization may not be designed to change individual health behavior; rather, it aims to create a social, political, and institutional climate that is receptive to the development and implementation of effective prevention programs.

An example of Community Mobilization is worksite-based informational seminars designed to dispel myths about HIV/AIDS. This correction of misconceptions may be intended to reduce discrimination against HIV-positive persons or persons whose lifestyle places them at risk for HIV. Another example is that of educational materials directed at parents and members of school boards, the objective of which is to create an environment within which school-based risk-reduction information might be facilitated.

CDC Guidelines for Community Level Interventions

From the CDC "Guidelines for Health Education and Risk Reduction (HERR) Activities, March 1995

Community Level Intervention combines community organization and social marketing -- a strategy that takes a systems approach. Its foundation is an assumption that individuals make up large and small social networks or systems. Within these social networks or systems, individuals acquire information, form attitudes, and develop beliefs. Also, within these networks, individuals acquire skills and practice behaviors.

The fundamental program goal of Community Level Intervention is to influence specific behaviors by using social networks to consistently deliver HIV risk reduction interventions. Although the intervention strategy is community-based, Community Level Interventions target specific populations -- not simply the community in general. The client populations have identified shared risk behaviors for HIV infection and also may be defined by race, ethnicity, gender, or sexual orientation.

In order to influence norms that support HIV risk reduction behavior, Community Level Interventions are directed at the population, rather than at the individual. The primary goal of these interventions is to

improve health status by promoting healthy behaviors and changing those factors that negatively affect the health of a community's residents. A specific intervention may take the form of persuasive behavior change messages, or it may be a skills-building effort. Whatever its form, an intervention achieves reduced HIV risk by changing group norms to improve or enhance the quality of health for members of the client population. These norms may relate to condom use, contraceptive use, or needle sharing. They may also focus on diagnosis and treatment of sexually transmitted diseases or HIV-anti

It takes time to change social norms. Social norms cannot be changed quickly or at the same rate that knowledge acquisition or skills development can occur. Change occurs as a result of sustained, consistent intervention efforts over time. The intervention must be implemented thoroughly throughout the social networks. A firm grounding in behavioral theory is essential to the development and implementation of Community Level Interventions.

Community-based needs assessment is critical to the development and implementation of Community Level Interventions. This phase is important for identifying and describing structural, environmental, behavioral, and psychological facilitators and barriers to HIV risk reduction. To successfully conduct this intervention, a program must identify the sources for and patterns of communication within a social network. Peer networks must be defined and described.

Note: Community Level Intervention is referred to as Community Intervention Programs in Program Announcement #300.

The following questions should be considered in designing community level interventions:

- Who are the gatekeepers to the client population?
- What are the important points of access?
- What are the appropriate and relevant risk-reduction messages, methods, and materials?
- What are the linguistic and literacy needs of the client population? A needs assessment should yield this vital information.

A variety of methods exist for collecting the answers to these questions. It is recommended that programs select the method that is most appropriate for their professional orientation (e.g., social work, health education). Whatever method is chosen, it is critical that the formative activity be community-based and as collaborative as possible with the client population.

The information gathered during the formative phase provides the foundation on which an effective program can be built. Completing this activity should result in culturally competent, developmentally appropriate, linguistically specific, and sexual-identity-sensitive interventions that promote HIV risk reduction.

Members of existing and relevant social networks can be enlisted to deliver the interventions. Other peer networks may also be created and mobilized to provide intervention services. This, of course, means volunteer recruitment and management. Community Level Intervention strategies offer opportunities for peers to acquire skills in HIV risk reduction and, in turn, reinforce these abilities when the peers become the teachers of these same skills to others.

In this manner, Community Level Interventions become community-owned and operated; thus, they are more likely to be sustained by the community when the program activity is completed. Social norms changed in this way are likely to have a long-lasting and effective impact upon HIV risk reduction.

Harm Reduction

From the 2001 San Francisco HIV Prevention Plan

This strategy accepts that harmful behavior exists, and the main goal is to reduce the negative effects of the behavior rather than ignore or pass judgment on the person or the behavior. The term "harm reduction" is used most often in the context of drug use, but the approach can be used with sexual risk behavior as well. A harm reduction approach encourages safer drug use or sexual practices among those engaging in high-risk behavior, and acknowledges the social and environmental factors such as poverty and racism that affect drug use.

Agencies should attempt to reach clients "where they are" to assist them in making choices toward better health. Be attentive to the health and well being of the entire person in considering when to use harm reduction options. Should be designed for a specific target audience, taking into consideration the population's norms and behaviors.

Harm reduction:

Strengths

Harm reduction:

- Can be used in an institutional (e.g., drug treatment facility) or community (e.g., outreach) setting.
- Can encourage safe injection practices and condom use.
- Can encourage positive risk reduction attitudes.
- Can provide linkages to drug treatment.

Limitations

Harm reduction:

- Does not eliminate the potential harmful effects of a behavior.
- May not be as useful for individuals not ready to change harmful behaviors.
- May lead to increased harmful behavior if not implemented well (e.g., a harm reduction message that encourages withdrawal before ejaculation could inadvertently lead to decreased condom use or increased number of sex partners).

Effectiveness

A large number of studies establish the effectiveness of a harm reduction approach in regard to high-risk injection behaviors and sexual behaviors, particularly when used in combination with counseling and health education.[1] Several studies of methadone maintenance programs show that substitution of an oral opiate for injection reduces high-risk injection behaviors and risk for HIV. [1] In one San Francisco study, participation in methadone maintenance for one year was shown to be highly associated with not becoming HIV-positive, although African-Americans experienced a significantly higher rate of seroconversion compared with Whites[2]. A harm reduction approach to injection drug use is also an effective secondary prevention technique, decreasing the risk of progressing from HIV to AIDS for HIV-positive IDUs. [1] Condom use is also an extremely effective harm reduction intervention for decreasing risk for HIV infection and has not been shown to increase or encourage sexual behavior when used with adolescents.[3]

References:

1. Brettle RP. (1991) HIV and harm reduction for injection drug users. AIDS 5:125-136.

2. Moss AR, Vranizan K, Gorter R, et al. (1994) HIV seroconversion in intravenous drug users in San Francisco, 1985-1990. AIDS 8(2):223-231.

3. CDC. (1999) Condoms and their use in preventing HIV infection and other STDs. September; http://www.cdc.gov/hiv/pubs/facts/condoms.pdf

Needle Exchange

From the 2001 San Francisco HIV Prevention Plan

Needle exchange programs are community or street-based programs that provide sterile needles to IDUs and hormone, steroid, vitamin, and insulin users. Needle exchange can be primary (i.e., individuals exchange their own needles) or secondary (i.e., individuals exchange needles for friends or a group of people).

Needle exchange sites should:

- Be adequately staffed and provide safer injection supplies.
- Have a designated health education and referral and resource person.
- Offer passes that reserve spots in drug treatment programs (i.e., drug treatment vouchers) to interested clients, when possible.
- Have available condoms, dental dams, and information on safer sexual behavior.
- Meet the safety needs of clients (e.g., minimizing police presence, having a protective and vigilant staff).

Agencies should:

- Consider collaborating with other HIV prevention education agencies to provide services at the needle exchange site.

Strengths

Needle exchange programs:

- Can be developed for a particular neighborhood.
- Can provide a bridge to drug treatment, CTR/PCRS, hepatitis C screening, and other social and medical services.
- Can be useful for the transgender community, and for other people who inject steroids or vitamins, as well as for IDUs.
- May be more appropriate than pharmaceutical outlets for higher-risk populations who may require ancillary services and other prevention tools. Can reduce transmission of hepatitis B and C as well as HIV.

Limitations

IDUs:

- Do not always know how to access needle exchange because they do not know the schedule or where to go.
- May not always consider needle exchange sites to be safe because they fear that law enforcement officials or social service authorities will intercept them there.
- May fear that their children will be taken from them if they participate in needle exchange.

Needle exchange:

- Is inappropriate in the context of a 24-hour residential treatment program and may not be appropriate for clients in other kinds of drug treatment programs.
- Cannot be funded with federal (or District of Columbia) funds at the present time.

Effectiveness

Needle exchange is clearly an effective intervention.[1] Several studies have found use of needle exchange to be associated with reduced needle sharing and other injection-related risk reduction behaviors[2] as well as reduced HIV transmission.[3] A review of the literature, including government reports, overwhelmingly supports the effectiveness of needle exchange.[4] Two studies indicate that it is a cost-effective approach in terms of infections averted (Holtgrave et al., 1998; Lurie et al., 1998).

References:

1.CDC. (2000) Syringe exchange programs. June; http://www.cdc.gov/hiv/projects/idu-ta/facts/ aed_idu_syr.htm

2. Guydish JR, Clark G, Garcia D, et al. (1995) Evaluation of needle exchange using street-based survey methods. J Drug Issues 25(1):33-41. Hagan H, Des Jarlais DC, Purchase D, et al. (1991) The Tacoma syringe exchange. J Addict Dis 10:81- 88. Watters JK. (1994) HIV infection among female injection drug users recruited in community settings. Sex Transm Dis Nov/Dec:321-328.

3. Heimer R, Khoshnood K, Stephens PC, et al. (Undated Manuscript) Evaluating a needle exchange program in a small city: Models for testing HIV-1 risk reduction. New Haven, Yale University School of Medicine. Unpublished manuscript.

4. Vlahov D, Junge B. (1998) The role of needle exchange programs in HIV prevention. Public Health Rep 113(Suppl 1):75-80.

5. Holtgrave DR, Pinkerton SD, Jones TS, et al. (1998) Cost and cost-effectiveness of increasing access to sterile syringes and needles as an HIV prevention intervention in the United States. J Acquir Immune Defic Syndr Hum Retrovirol 18(Suppl 1):S133-S138. Lurie P, Gorsky R, Jones TS, et al. (1998) An economic analysis of needle exchange and pharmacybased programs to increase sterile syringe availability for injection drug users. J Acquir Immune Defic Syndr Hum Retrovirol 18(Suppl 1):S126-S132.

Using the Internet for HIV Prevention [1]

There are many different kinds of Internet- and computer-based HIV prevention strategies, including listservs, chat rooms, electronic bulletin boards, informational websites with links to resources, and computerized surveys and assessments. These can be used in the context of individual interventions (e.g., email exchanges between client and provider regarding risk reduction), small group interventions (e.g., single session group workshops done in a chat room), or community-level interventions (e.g., an Internet media campaign).

Agencies can reach large numbers of people over a wide geographic area using the Internet, can access their target populations using the same channels that people use to solicit sex partners (e.g., chat rooms)[2]. In addition, interactions on the Internet may be perceived as more anonymous and thus may be more useful for populations desiring anonymity.

There are limitations to this strategy. It will not reach those without Internet access or computer skills, who may be low income or marginalized groups and at high risk for HIV, and it may compromise anonymity/confidentiality if identifying information is requested or given over the Internet.

Agencies should develop user-friendly, interactive approaches and provide training (and advocate for training in schools) on how to use computers and the Internet to access HIV-related information and resources.

Effectiveness. The effectiveness of Internet and computer strategies for HIV prevention has not been established. One study showed that a computer-based prevention strategy that assessed condom attitudes, condom use behavior, and readiness to adopt consistent condom use was acceptable to a group of high-risk women, who reported that they liked the feedback the computer gave them and would recommend the program to a friend[3].

References:

1. 2001 San Francisco HIV Prevention Plan

2. Bull SS, McFarlane M. (2000) Soliciting sex on the Internet: What are the risks for sexually transmitted diseases and HIV? Sex Transm Dis 27(9):545-550.

3. Brown-Peterside P, Redding CA, Ren L, et al. (2000) Acceptability of a stage-matched expert system intervention to increase condom use among women at high risk of HIV infection in New York City. AIDS Educ Prev 12(2):171-181.

DISTRICT OF COLUMBIA HIV COUNSELING AND TESTING POLICY

October 1999

BACKGROUND

Acquired immune deficiency syndrome (AIDS) has become one of the major health problems in the District of Columbia and across the nation. As part of the District's comprehensive program to combat AIDS, an extensive AIDS education program has been developed to prevent further transmission of the disease. A major component of this program is the provision of voluntary human immunodeficiency virus (HIV) antibody counseling and testing services by the Department of Health. These services are provided on both a confidential and anonymous basis.

THE TEST

The HIV antibody test detects the presence of antibodies in the body. The test was originally made available to protect the nation's blood supply by screening donated blood. The test has since been made available on a much wider basis, enabling individuals to learn their antibody status.

The HIV antibody test is not a test for AIDS. The test does not tell if a person has or ever will develop AIDS or any AIDS-related condition. The test does show whether a person has been infected with the virus known to cause AIDS.

The Department of Health provides HIV antibody testing for individuals interested in knowing their antibody status when deemed necessary as part of a medical evaluation; as an alternative to using blood banks to obtain antibody status; and for research purposes.

ANONYMOUS TESTING

Anonymous testing is designed to ensure that the identity of a person taking the test is not associated with the test or the results. A person requesting anonymous testing is not identified by name, but by a code. Anonymous testing is available at several alternative test sites on a walk-in or appointment basis.

Procedures for Anonymous Testing

1. Patients must receive explanation of procedures used for anonymous testing and availability of confidential testing.
    - No names are used;
    - No record of test result;
    - Blood tests submitted to laboratory anonymously using seven-digit initial date of birth codes; and
    - Client must return in person for results
2. Patients must receive prevention (pre-test) counseling providing:
    - Information about what the HIV antibody test is;
    - Assessment of risks for HIV-infection;
    - Explanation of what the test results mean and limitations of the test results;
    - Prevention/risk reduction information; and

- Incremental risk reduction plan.

3. Test results must be given in person:
    - Test results will only be communicated to the patient in person during a pre-arranged post-test (post-test) counseling session;
    - Under no circumstances are test results ever to given out over the telephone or through the mail.
    - Positive test must be verified by a repeat Elisa test, and if still positive, confirmed by Western Blot analysis before patient is told of results; and
    - Written verification of test results will be provided to the client with their written consent.
4. Patient must receive post-test counseling:
    - All patients will be counseled about the meaning of test results and appropriate prevention/harm reduction measures;
    - All individuals testing positive will be counseled about spousal/partner notification of their antibody status. The law requires that a provider "must make a reasonable effort to notify any individual who is the marriage partner of an HIV infected patient, or who has been the marriage partner of that patient at any time within the 10 year period prior to the diagnosis of HIV infection." The Department of Health provides "Partner Notification Services." Partner Notification shall be conducted in accordance with the Centers for Disease Control and Prevention Guidance dated October 1998.
    - All individuals will be counseled to inform their health care providers of their antibody status.
    - Referrals for Case Management and or Primary Medical Services will be made when appropriate.

CONFIDENTIAL TESTING

Confidential testing occurs when the health care provider knows the identity of the individual, but the results of the HIV test will not be disclosed except in accordance with the consent form signed by the patient. Confidential testing will be offered by persons who have a history of high-risk behavior, persons with clinical signs and or symptoms of HIV, and persons who request the test.

1. Patient/Client must receive an explanation of procedures used for confidential testing:
    - Written informed consent required;
    - Test results become part of patient's medical record and maintained in a confidential manner.
2. Patient/Client must receive pre-test counseling providing:
    - Information about what the HIV antibody test is;
    - Assessment of risks for HIV-infection;
    - Explanation of what the test results mean and limitations of the test results;
    - Prevention/risk reduction information; and
    - Incremental risk reduction plan.

3. Patients must give informed consent in writing after the informed consent form is explained:
    - Antibody test will not be given without written consent;
    - Consent form and test results will be placed in the patient's medical record and maintained under strict security.
4. Test results must be given in person:
    - Test results will only be communicated to the patient in person during a prearranged post-test (post-test) counseling session;
    - Under no circumstances are test results ever to given out over the telephone or through the mail.
    - Positive test must be verified by a repeat Elisa test, and if still positive, confirmed by Western Blot analysis before patient is told of results; and
    - Written verification of test results will be provided to the client with their written consent.
5. Patient must receive post-test counseling:
    - All patients will be counseled about the meaning of test results and appropriate prevention/harm reduction measures;
    - All individuals testing positive will be counseled about spousal/partner notification of their antibody status. The law requires that a provider " must make a reasonable effort to notify any individual who is the marriage partner of an HIV infected patient, or who has been the marriage partner of that patient at any time with the 1 0 year period prior to the diagnosis of HIV infection". The Department of Health provides "Partner Notification Services". Partner Notification shall be conducted in accordance with the Centers for Disease Control and Prevention Guidance dated October 1998.
    - All individuals will be counseled to inform their health care providers of their antibody status.
    - Referrals for Case Management and or Primary Medical Services will be made when appropriate.

FEES

Confidential services at the SE Sexually Transmitted Disease Clinic, TB Clinic, Addiction Prevention & Recovery Administration, HAA grant/contract funded programs, and Public Benefit Corporation Health Clinics staffed by HAA counselors', are provided free in the public interest. There will be no charge for HIV counseling & testing services at these locations.

POLICIES FOR PROTECTION OF CONFIDENTIALITY

All medical records, laboratory reports and consultation reports are to be maintained in a confidential and secure manner. No such data are to be left unattended. When not required by staff, all such data are to be kept in locked files or locked rooms, which are not accessible to non-staff members. Clinic/Program managers will be ultimately accountable for security of medical records and reports.

Any employee who is found guilty of violating the confidentiality of said medical records, reports, or related data would be disciplined in accordance with established personnel policy.

Written informed consent is required prior to HIV testing and will state that results of the HIV test bell be recorded in the patient's medical record. The medical record is available for review by appropriate clinic staff when necessary to receive medical services.

SUBMISSION OF LABORATORY SPECIMENS

All HIV blood samples, whether obtained through anonymous or confidential, will be submitted to the servicing laboratory using the first and last initials, and 6-digit date of birth of the person being tested. Laboratory specimens or lab slips will not have the name of the person being tested attached to them. Example (JD01 1052) John Doe date of birth January 10, 1952.